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ABSTRACT

These proceedings, intended to provide an outline of the basic concepts presented during the conference of administrators of multidiscipline health-related organizations and to serve as a stimulus for improving training programs in University Affiliated Facilities (UAFs), include 16 papers presented by conference resource persons. They are categorized under six headings: (1) Introduction and History of Administration (two papers), (2) Administration Training in the UAF Core Curriculum (three papers), (3) Preceptor-Intern Relationships (two papers), (4) Administration Degree Programs: UAF and University Relationships (four papers), (5) Nominal Group Technique (three papers), and (6) Administration Training: Funding Criteria and Future Possibilities (two papers). Appendixes contain the conference program and addresses of conference participants and consultants and resource persons. (HD)

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ADMINISTRATORS AS EDUCATORS

PROCEEDINGS OF A NATIONAL CONFERENCE

FOR

ADMINISTRATORS OF UNIVERSITY AFFILIATED FACILITIES

Edited By

R. Wilburn Clouse
John F. Kennedy Center for Research on
Education and Human Development
George Peabody College for Teachers
Nashville, Tennessee

February 23-25, 1976
Phoenix, Arizona

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PREFACE

During the past 5 years the administrators of the University Affiliated Facilities (UAF) and project management personnel from Maternal and Child Health Services (MCHS) have assumed a major role in the development of training programs for administrators of multidiscipline health-related organizations. Interest from UAF administrators and financial support from MCHS has stimulated a group of UAF administrators to embark on a plan to encourage and develop administration training at all levels in UAFs. This group has had an active plan for dealing with administration training since early 1973. MCHS and UAF administrators have a strong responsibility to develop and maintain administrative training programs. MCHS staff members and the UAF administrators are extremely conscience of this responsibility and/or continually seeking ways, techniques, and procedures to improve administrative training. This national conference represents one of the ways in which MCHS and the UAF administrators were working together to develop and improve administration training.

The papers in this volume constitute the proceedings of a national conference for administrators of University Affiliated Facilities on the theme of Administrators as Educators. The conference was held in Phoenix, Arizona on February 23-25, 1976. The purpose of these published proceedings is to provide an outline of the basic concepts that were presented during the conference and to serve as a stimulus for improving training programs in UAFs. While these proceedings represent an identifiable output of the conference, the volume by no means represents the total output of the conference. In addition to the papers presented by conference resource persons, MCHS staff members, and UAF administrators, many hours were spent discussing and debating concepts related to the training of administrators.

The UAF administrators gratefully acknowledge the continuing support that the Maternal and Child Health Services has given to the development of training

programs for administrators. We are indeed fortunate to have strong MCHS support from James Papai. At this time, we are especially grateful to MCHS and James Papai for the contract that made this conference and these proceedings possible.

I am personally grateful to the program committee composed of Jerry Elder, Charles Keeran, Adrian Williamson, Melvin Peters, and Robert Gray for their assistance in planning the program and in implementing the conference. A special note of thanks is due to Jerry Elder who served as co-host for the conference. The program committee, in return, is also grateful to each of the UAF administrators and to the conference consultants who participated in the conference. The consultants to the conference were Jack Malban, John Kralewski, Walter Burnett, Thomas Natiello, and Andre Delbecq.

Finally, I am extremely grateful to Mary Martin for her assistance in local arrangements and proof reading these proceedings, and to Doreen Kuehne for her enormously valuable service in the preparation of these manuscripts for publication.

R.W.C.

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INTRODUCTION AND HISTORY OF ADMINISTRATION TRAINING IN UAFs

Moderator

R. Wilburn Clouse
John F. Kennedy Center for Research
on Education and Human Development
George Peabody College for Teachers

OPENING REMARKS

R. Wilburn Clouse
The John F. Kennedy Center for Research
on Education and Human Development
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I would like to take this opportunity on behalf of myself and the conference steering comittee to welcome each of you to this National Conference for Administrators of University Affiliated Facilities. The steering committee has chosen the theme of Administrators As Educators for the conference. We believe this is a timely theme since many of you are in the process of improving or developing new approaches to administration training. We believe that University Affiliated Facilities (UAF) have a unique opportunity to develop multidiscipline training programs for health service administrators. This conference has been constructed around the concept that the complexities of modern society have generated an ever-increasing need for the administration of organizations that extends beyond the boundaries of a single discipline. When such administration involves the utilization of concepts, methodologies, and established paradigms from a number of disciplines, the result is often referred to as an interdisciplinary approach to management. Since UAFs are commissioned in part as multidiscipline training centers, we believe that many UAFs have the potential of expanding their training functions to include the training of multidiscipline administrators.

In the next two and one-half days we will have opportunity to review the major training models used for multidiscipline administration training and examine the role of the UAF administrator in the development of administrative training programs. We have been able to attract a number of outstanding individuals from throughout the country who are deeply involved in the various aspects of multidisciplinary administration. Conference speakers include

researchers, practicing administrators, educators, and funding agency representatives. Among the topics to be explored are the following: the importance of training programs for health service administration; models for interdisciplinary administrative training programs; continuing education for health service administration; internship/preceptorship relationship; the UAF administrator as an educator; group techniques for program planning and decision making; and funding patterns for multidisciplinary administration training programs.

The conference objectives as determined by the conference steering committee are as follows:

- To emphasize the importance of interdisciplinary administration training.
- To review the history and background of UAF administration training programs.
- To investigate the three administration training models in UAFs.
- To examine the role of the UAF administrator in teaching administration.
- To determine the requirements and role of a preceptor.
- To develop a plan for administration internship.
- To develop a plan for relating to academic health service administration training programs.
- To learn and apply the Nominal Group Technique in decision making.
- To explore funding possibilities for administration training programs.

I hope that in the course of the next few days we will come to better understand the role of a UAF administrator in the development of multidiscipline administration programs in UAFs and that each of us will formulate plans for improving or introducing administration training in our various programs. During the course of this meeting I hope that each of you will feel free to ask questions and to make relevant comments throughout the entire conference.

THE IMPORTANCE OF INTERDISCIPLINARY ADMINISTRATION TRAINING IN UAFs

William Gibson
The Nisonger Center
Ohio State University
Columbus, Ohio

Introduction

When you are invited to provide a theme address, it can be difficult. In front of this group, many of you who are personal friends, it is nigh impossible. Yet, I am flattered to be here with the administrators of the University Affiliated Facilities (UAF) in the presence of their strongest supporters from federal agencies, most notably our supporters from Maternal and Child Health Services, to discuss with you the role of the administrator in the academic profile of UAFs, both current and projected. To incorporate a sense of the historical perspective leading to this day, I would like to undertake a short review of where we have been, where we are now, and then attempt a discussion of where we are going.

Initiation of the first UAF in 1964, brought into interface and communication, areas of government that had historically been concerned with the construction of hospitals and institutions with the professionals from the Children's Bureau. These two groups placed before universities and communities applications for projects demanding evidence of interdisciplinary functional operation in UAF programs. The Children's Bureau consultants, now known as Maternal and Child Health Services, immediately captured the critical role the administrator would play in such a program, if the bridging between university elements and community elements was to be reality. In the negotiation with local, state and federal agencies, the requirement and the responsibility of the administrator in the process is defined to be one of a "knight" rather than a "pawn" in the interplay.

The Maternal and Child Health Services staff in Washington clearly stipulated their desire to support the administrator as a professional in the organizational structure and required a description of his role, stipulating the independence of his function in relationship with other professionals. That led to the obvious relationship between administration and education in the total UAF program.

The American Association of University Affiliated Facilities, likewise from its earliest days, envisioned the administrators of the programs as persons sharing equal responsibilities with the program directors, demanding their visible presence in the executive structure and requesting their leadership as presidents of the organization.

It is worthy of note that Charles Davis, Administrator at the Birmingham center, was the fourth president of the organization and the individual who supervised the implementation of a Washington office to carry out communication, evaluation and planning roles on behalf of member UAFs.

The need for appropriate administrative staffing was also picked up by the Developmental Disabilities Division. In their first mental retardation legislation, a number of trial placements of money for support of administrative elements were audited to determine what impact they would have on the development of programs. The response was positive, so that in both the recent and current developmental disabilities legislation, the language under the UAF section continues to define support for administrative personnel as one of the priorities.

The Importance of the Administrator

With this history in mind, let us now look at the role of the administrator in the interdisciplinary mileau provided by the settings where you are employed. A strong link with the university is critical. For many of you, it is a link with a number of universities that are critical to the maintenance of an

appropriate program. This relationship with your university requires a two-way educational stream where you become acquainted with and responsible to the organizational personalities of the universities, their planning and auditing system, as well as persons knowledgeable of the multiple services needed for the maintenance of your program. In return, you present to the administrators, a problem in support through divergent areas of funding and commitments to project responsibilities. These needs frequently go beyond the guidelines they have developed through their previous years of operation. Your consistency and diplomacy, as well as the drive and determination, remain the ingredients of broad interaction with the university.

The second major area of responsibility is your maintenance of the link between the UAF and the community. While universities frequently offer lip service to community involvement and interaction, it is frequently of the hit and run variety. A university professor runs downtown, makes a speech and streaks for the ivy covered halls to sustain his isolation from the reality of the world around him. Contrast this with your need to bring the world to the university, to educate universities about sources of community and state funding, and explain why they are not always prepared to recognize university overhead costs, or are in favor of assigning you monies for projects with contract rights that allow them to participate with you in the ongoing management and review process that is a product of this mutual agreement.

The activities I have mentioned, demonstrate confined administrative interaction with the community. For effective function, the administrator must also become identified with organizations, activities and agencies at the community, state and federal level where his presence, as well as the knowledge he contributes, will be reflected in community persons seeking your advice in their overall planning and support as a representative of a UAF. It may be difficult to understand why you must give testimony at the state level on a hearing for Title XX of the Social Security Amendment, but it would be equally

upsetting if the state agency administering this funding would be allowed to totally ignore the training aspects of the regulations and, in particular, the application of the social security legislation to include services for the mentally retarded and developmentally disabled. In a number of UAFs, the visability of their administrators at the state and national level has been an integral part in the success of the total program. It is hard to ignore the impact of persons such as Vic Keeran of UCLA, Harvey Stevens from Wisconsin, and the Nisonger Center's Vern Reynolds, all of whom had considerable previous experience in community action prior to becoming UAF administrators and who have maintained these ties as an important part of their UAF administrator's responsibilities.

The third major determinant of administrative function is the introduction of feasibility in review of proposals submitted on behalf of the total program. You each receive a constant barrage of requests for the development of the most illustrious programs, only to learn that the faculty and other professional advisors involved, have totally ignored fiscal realities or administrative principals necessary for the appropriate operation of a project.

The weighing of feasibility by the administrator can be a tender problem. Here, the emotional and reality relationships must be placed in an equation to see whether a particular project does indeed fall within the intent of the UAF mandate. Should this be the case, is the funding suitable for the implementation of the goals and objectives stated in the proposal? All too often, the pressures for facilitation, moral conviction and changing direction manifest by changing federal and state administrations, can tempt programs to pursue activities that may place them in a subservient role to the primary training mission.

The review of proposals, particularly in light of the budgetary realities, is an important part of the administrators function. Even in the early stages of projected proposal development, it is important to have the administrator

involved, so that budgetary advice can be incorporated and so that reviewers of a proposal are sensitive to the cognizance of the group submitting the application toward the reality of achieving the reality of their commitments. In the present role of UAF administrators, it is not uncommon for a very brief notice to be available prior to the processing of a proposal through university and other review process. This makes it even more urgent that all UAF personnel commence dialogue with the administrators at the time they first have a desire or see an opportunity for a project. This could avoid the tragedy many of you have commented upon when the funding of a proposal further erodes the fundamental commitment of professional persons in the UAF for their primary responsibilities.

The administrator has the requirement to review with the faculty and other members of the management team, the total present and projected budgets for the operation of the UAFs. When questions are asked regarding fiscal feasibility, it is the administrator who must be prepared to answer questions, both within and without the UAF. The planning function of the administrator requires data to make appropriate decisions so critical in the preparation of a budget.

Historically, many universities operated with limited capacity to document for audit funds from individual budgetary sources. In our present society this is part of history. The preparation by the administrator of a bookkeeping system linked with the university able to stand up to auditing is considered a normal function of the position. But even with computers and sophisticated accounting, human errors still exist. The effective administrator is both aware of the flow of monies and sensitive to errors in print-outs that might result from inappropriate encumbering of funds from an account of his or her responsibility.

The recruitment and selection of appropriate personnel for faculty and staff is a primary function of the administrator of a center in concert with

the director. The consideration of all key persons who join a UAF requires the active interviewing, comment and participation by the administrator of the program, whether participants in positions prove from primary support areas, or individuals employed for a period of time to participate in a project. At the Nisonger Center, faculty are chosen by a joint committee of the Center and the academic department with final review by the administrative core of the director, associate director and the administrator. Staff positions are selected through appropriate review by project directors with the approval of the administrator. All other personnel are screened, selected and placed in the program by the administrator. The recruitment of support persons whose functional category represents a civil service equivalent is greatly enhanced by demanding appropriate job descriptions. The talents of persons selected by faculty for their friendly nature and non-threatening incompetence can be costly to your organization.

Another critical activity of the UAF administrator is the projection of functions of the program into the future. This is a high priority item with each of you and is presently influenced by the extent of your participation with Coralie Farlee and the executive staff of the AAUAF Committee looking into the long range planning for all UAF programs. The questions require data upon which to make judgments. This, for each of you points out the need to have a functioning evaluation system where the information obtained can give evidence of productivity and the evaluation materials can be used in decision making of the overall program. UAFs are complicated structures, but it is still necessary to substantiate and correlate productivity, measure cost effectiveness and develop numerical units that can be used in comparison with other elements of the university and community program operations. Unless a closed linkage exists between the administrator and the evaluator, and unless both parties are cognizant of the basis upon which functional measures are taking place, it is

difficult to defend the painful decisions demanded of each of us as we try and maintain optimum function with diminishing support dollars.

Research in the administrators role has been placed at the end of his responsibility flow. The interaction between the administrators and other faculty in applied research has tended to reflect their prior disciplinary skills, rather than models of research analytical of the administrators role and the comparative factors that influence it. It is to be hoped that in the future, this might become an expanding area.

My memory takes me back a few years to a time when I first discussed a model for evaluation of a UAF with consultants of the Maternal and Child Health Services Program and with the Developmental Disabilities Office. The responses to a systems model were interpreted along the strict disciplinary horizon of the person and the data seen as a detective mechanism to expose incompetence, rather than a means of decision making for program operation and upgrading. The past few years has seen a profound change occur in this area. I remain optimistic that a similar extension of the research role of UAFs and the incorporation of the administrators as a discipline interested and involved in applied research will be initiated as a result of your activities.

The Role of the UAF in Administration Training

Now, I would like to turn to the reason we are meeting in this beautiful location today. Over and over again, we hear the professionals and agencies we interact with at the community, state and federal level express to us the advantages that increased administrative skills would add to the functional application of their role and the overall success of their operations.

In the brief time that UAFs have been in existence, a reversal has been seen in the type of skills and competencies sought for in selecting the directors of institutions for the mentally retarded and developmentally disabled. In the 1950s it was unheard of to employ a nonphysician as a director of an institution.

In the 1960s, several trend-setting areas were able to demonstrate a systems operation where definition of the administrator's role and the medical director's role placed primary decision-making for the institution in the administrator's hands with considerable upgrading of operating efficiency. At present, across the nation the requirements for both institutional directors, community, county and district program operations states the desirability of administrative skills as part of the background experience of suitable candidates. In Ohio, we have seen this from other points of view. On each occasion where we met with the Director of the Division of Mental Retardation and Developmental Disabilities at the state level to discuss training priorities, the number one priority given us was increasing the administrative experience and competence of persons within the state organization. Through the years of meeting with rehabilitation services at the state level, it was pointed out that their primary need was to add to the basic education of the rehabilitation counselor through providing such an individual with administrative experience, so that the management echelons of the state rehabilitation services could function in a fashion of decision-making and reflect a knowledge of management, as well as systems operations. The same request was made of us when we interacted with the state and federal areas of education and social welfare.

Even the physicians are beginning to admit their role in the delivery of health-related services might be more effective measured by an equation reflecting a diminution in omnipotence against an increasing knowledge of the administrative principles necessary for improvement of health services. This attitude in our society is further reinforced with the selection of administratively trained persons to head community-based, or regional health programs that might well be antecedents of a nationalized health plan.

From this you can see in UAFs we are continually being faced with indicators of professional persons stating they see administrative skills as a top priority. Statements by agency personnel of the birth of administrative training in their

professional staff is equated with a changing sociological model where the administrator is upgraded in relation to professional persons without administrative skills. This leads to the current trend to create models of community and institutional operation with the leadership role assumed by the administrator. But, the critical problem then quickly surfaces in the fact that while the obvious trends exist and the statements are made in sincerity, there is little evidence in UAFs that we are being used as centers in which to achieve administrative goals outlined by the leaders in community and government planning. This places before each one of you a problem similar to the one I described with regard to evaluation, where we must begin to quietly and effectively implement elements of administrative training in UAF programs, so that the threat envisioned by professional contact with an individual possessing administrative knowledge will be seen as a positive rather than a disruptive factor in planning. As these individuals seek the university to discuss the need for administration training, we should have few doubts that they see in the UAF and the university the site for creation of the models of administrative education in function and structure, where the theoretical and practical elements of administration can be learned and applied. Let us learn from the experience of the schools of public health who created administrators whose technical skills were laudatory, but whose capacity to interact at the community level was questionable. Existing programs should serve as areas for analysis in preparing your own implementation of administrative courses and practicum experiences.

Now what should be our approach? First, we need to identify the students among those we are presently serving in our interdisciplinary programs who see the addition of administrative courses and experience as part of the reason they are seeking out the UAF for part of their educational experience. Both the University of Michigan and Ohio State have offered a practicum experience involving participation in the direct administrative activities of a UAF by means of placing an extra desk in the administrator's office and the director's

office, having students designate time they would spend, and allowing them full access to the planning and decision-making process, as well as assigning them a responsibility in an administrative developmental area. If a student indicates that beyond a component part of a course for which they are already receiving credit a desire to acquire administrative knowledge, then it becomes important for the UAF to develop within your university appropriate course credit for an elective administrative practicum. This step should bring you into a working relationship with the college of business, or college of administrative sciences on your campus, or related university.

The next level is a combined curriculum and practicum in administration. At Ohio State University, we were able to identify in the public administration section of the College of Administrative Sciences a group of faculty whose views on administrative functions were more practical than the more theoretical and mathematical programs offered by the graduate program in preventive medicine. Through a series of meetings, it was possible to work out two plans. The first, for a 12-month experience leading to a certification in administration. This is open to presently employed professionals in MR/DD related areas and it includes a balance of course work in budget planning, management principles, accounting, systems design, basic computer science and wedded to a practicum experience in the administrative section of the UAF. The second program agreed upon works toward obtaining a masters degree in public administration from the College of Administrative Science. Candidates must be eligible for admission to the graduate school. The curriculum is a 2-year combination of the basic business principles previously listed with a practicum in the UAF, as well as assignments for experience in community and institutional programs. At this time, I am under the impression that three UAFs offer a similar or equivalent program leading to a masters degree. The third level which we have not achieved would be a doctoral program. Here again, the expectancy would be demonstration of course proficiency in the area of management, accounting, planning, use of

systems, evaluation, program implementation and computer sciences, plus research in the application of an interdisciplinary program. At this time, I am under the impression that one UAF offers such a program.

It is my hope it has been possible for each of you to share with me the sense of importance that administration is taking on in the total UAF program across the nation. The society is indicating its need and sociologists find evidence of changing criteria in the assignment of education priorities for professional leaders. The predictable future of the UAFs will certainly demand from their administration what has been demanded of all of us in the area of evaluation, that we demonstrate both commitment to and operational program elements in this important area. To create the student interest, they will need to have open access to the administrative elements of the program and be allowed to participate with you in the decision-making meetings of the organizations both within the university, as well as the UAF's relationship with community and governmental bodies. It is necessary to increasingly involve students in problem-solving areas demanding administrative skills with the knowledge value such experience provides to enhance the prospects for career promotion. An appropriate administrative program needs to maintain a balance in communication with the academic area that it represents recognizing the commonality of principles in the basic courses and the offering of practicum experience specifically applicable to interdisciplinary programs in the field of MR/DD. To identify the problems that exist, the community has to identify the administrators as critical to them in their problem-solving. Thus, you need to schedule yourselves and your students into obvious participation with community agencies, developmental disabilities councils, regional, national administrative and academic organizations.

Why is this meeting so important? I hope it is obvious to you based on the reflection of your day-to-day role, as well as the projection of your role in the future, that we are dealing with a void in society. The information

provided by graduates moving out of the Nisonger Center program is complementary to us in regard to the rapid rate in which these professionals have assumed prominence throughout the state in the area of MR/DD. The presence of a void that was waiting for UAF products is reflected in their comments. They move up too quickly in areas of responsibility, they then write and tell us they wish they had spent more time in preparation of these administrative skills being demanded of them. They want to acquire the background needed to create, plan, implement and audit their activities. They admit their naivety in areas of administrative skills and hope that in the future we will not overlook the incorporation of administrative experiences or disciplines as well as the opportunity for graduate education to achieve advancement through study in this area. These people are particularly sensitive to their inability to interpret the relationships between legislation and program development, through the utilization of the tools of administrative planning. It is my hope that it will be possible for each of you during your sessions at this conference to agree upon the common criteria by which you would like to have administrative education judged as a training component. Remember it is 1976 and avoid if you can ritual commitment to curriculum structure where the end product reflects well on the university for courses passed and grades achieved only to have to undertake a relearning, reorientation internship at the community level because this necessary part of the practicum could not be written into the program.

The province of Ontario has developed a career ladder-lattice program to define the functional educational needs for MR/DD programs you should review prior to transplanting the overeducated, underequipped academic product shown by Carnegie Foundation Research on the market. Both these reports highlight the systems planning approach to preparation of persons for career roles and give credit to recognition of the reality of experience on the job as a major learning source. The top candidates for administrative training are going to emerge from the marketplace, not the parochial university sequence of high

school, college and graduate training. Please respect their intelligence gained through experience and work to avoid insulting this maturity by course preparations remote from reality.

In summary, I feel that the timing is appropriate. I hope that as a product of this meeting, a sequence of administrative programs demanding the practicum experience of an interdisciplinary nature can be developed.

HISTORY AND BACKGROUND OF UNIVERSITY AFFILIATED FACILITY ADMINISTRATIVE TRAINING PROGRAMS

Jerry O. Elder
Child Development & Rehabilitation Center
University of Oregon Health Sciences Center
University of Oregon
Portland, Oregon

Introduction

My role this morning is to provide you with some background information to bring you up to date on how we got to this point on the subject matter of administrative training in UAFs and why we are here for the next two and one-half days. In the last few years there has been considerable interest expressed concerning the need to better educate and train administrators of UAFs and more broadly, administrators of mental retardation and developmental disability programs. The National Advisory Council on Developmental Disabilities, the President's Committee on Mental Retardation, the Maternal and Child Health Services as well as others have all expressed an interest in this area. There has been much talk but very few proposals submitted by individual institutions attempting to meet this need. Very little substance has come out of all this rhetoric. As practicing managers we can see the need for upgrading administrative skills of existing administrators and for the adequate preparation of the new administrators coming into the field of mental retardation and developmental disabilities.

First Effort - Core Curriculum Plan

A small group of concerned and dedicated administrators first met in May of 1973 in Denver, Colorado to tackle this problem. With the exception of Walter Throop, who left the UAF at the University of Southern California in 1974, all administrators who were at the initial meeting are still working on the problem. At the session in Denver, we developed a core curriculum of

administrative subjects that all disciplines with UAFs should be taught. With each committee member developing one subject area we published a document entitled "Administrative Content in Interdisciplinary Training." The intent of this document was not to make administrators out of other disciplines but to provide some understanding to other professional disciplines in order that as supervisors within their own disciplines they would function better as program managers and be able to work better with their administrator. The document urged the following subject areas be taught to all disciplines within UAFs:

1. Health Care Delivery System
2. Administrative Concepts
3. Planning and Organization
4. Coordination, Communication, Delegation and Control
5. Developing Tasks Lists and Performance Standards
6. Personnel-Hiring, Developing and Evaluating
7. Program Development, Funding and Administration

Second Effort - Management Improvement Workshop

At the same Denver meeting the need was also expressed to upgrade the skills of existing UAF administrators. The possibility of funding a management improvement workshop from the Maternal and Child Health Services was discussed and we were successful in obtaining funding for such a workshop, which was held in New Orleans in November 1973. This highly successful workshop was conducted with the help of the graduate program in health services administration at the Tulane University School of Public Health in New Orleans. Proceedings of that workshop were published and I have brought along a few copies to distribute to those new administrators in UAFs who do not have one. This workshop gave us the first opportunity for the 45 UAF administrators present to meet separately and discuss mutual problems, and it was very evident there was a need to better educate existing administrators along with those

coming into the field. We left that meeting with the understanding that something must be done and a small group of administrators expressed their willingness to volunteer to serve on a committee to do something about it. What, we were not exactly sure.

Third Effort - Position Paper on Administration Training

Impetus for the next step came in April 1974 when we approached the Maternal and Child Health Services to fund a grant application to extend our committee's efforts for another year. We were successful in obtaining funding for that project and the planning committee first met in May of 1974 at the AAMD meeting in Toronto. At that meeting we clarified the three groups to which we were addressing our project: (a) the nonclinical administrator who has had some administrative training; (b) existing administrators, including professionals, who have not had previous training as administrators, but have had administrative and management responsibility; and (c) the graduate level student studying for a degree in administration. It was decided to develop a questionnaire to ascertain the skills and competencies administrators should possess and to obtain a general idea of the need for administrators in the MR/DD field. The results of this questionnaire would be the basis for the development of a graduate level curriculum in administration. This questionnaire was an important part of our project and provided us with valuable input that resulted in the publication of our position paper entitled "Education of Administrators in an Interdisciplinary Model." It was decided also to work closely with existing graduate programs in health administration and with the Association of University Programs in Health Administration (AUPHA) in our endeavors.

Fourth Effort - Task Force on Mental Health and Mental Retardation

About the same time, another group was beginning to work on the problem of educating administrators in the mental health and mental retardation fields. This was the Task Force on Mental Health and Mental Retardation Administration

jointly sponsored by the Association of University Programs in Health Administration, the American Psychiatric Association and the Association of Mental Health Administrators. Over a 3-year period, this Task Force is studying the problem of administrator education and developing a curriculum and recommendations for solutions in this area. Fortunately, Vic Keeran is one of the Task Force members and is also a member of our UAF administrative training project committee. This has facilitated coordination and cooperation between our efforts and those of the Task Force.

With the help of Dr. Walter Burnett, whom you will hear from this afternoon, our committee worked closely with the AUPHA in developing our position paper. In our Toronto meeting, we originally proposed to meet in the Fall of 1974 with the directors of four or five graduate programs in health care administration from various schools with differing philosophies to help us develop a curriculum. However, this was delayed until after the first National Conference on Education for Mental Health Administrators which was held in March, 1975. This conference was sponsored by the National Institute of Mental Health and was organized by the Long Term Care Office of the Association of University Programs in Health Administration. Pat Cahill, who is director of that office, has worked closely with our committee and has been a valuable asset in our deliberations.

The New Orleans conference brought together for the first time administrators, primarily of mental health organizations, and educators throughout the country. The conference consisted of a series of papers and small group discussions on what the administrative function is in mental health programs. Reactions to the entire conference were very positive. However, the papers delivered were redundant. It was discovered that although an administrator for a community mental health program and an administrator of a large state system were looking at administration from two different vantage points and NIMH was looking at it from a third vantage point for an overview of the field, the kind of problems they all related in terms of administration for programs

and facilities were very repetitive. For example, they all discussed bureaucratic tangles. They also mentioned finances and combining a variety of financial resources in the problems of dealing with a variety of professionals. Other common problems were consumerism, evaluation and accountability to the public. By the end of the first day the participants wanted less being talked to and instead more small group kinds of interaction and wanted to get down to specifics. However, this was not possible at the initial conference and a second conference is in the planning stage now where it is hoped these types of issues can be addressed. The reason I have even mentioned this National Conference on Education for Mental Health Administrators is because the administrators on our committee have discovered that the type of management and administrative problems mental health administrators and mental retardation or DD program administrators experience are similar. Although there are very distinct and different program concepts between mental health and mental retardation, the problems administrators experience in managing these organizations are almost identical. There is a section in the position paper dealing with these similarities.

Fifth Effort - Graduate Program Curriculum

The next meeting of our administrator's training project's planning committee met in Denver the end of March 1975 with representatives of four widely varied graduate programs in health care administration as well as Pat Cahill from the AUPHA. Three of those four graduate program directors are with us today and will speak on the program this afternoon. The original purpose of the Denver meeting was to develop a curriculum for graduate education in MR/DD administration. However, after the National Conference on Education and Mental Health Administration, it became apparent we were rather presumptuous and premature to propose a curriculum that would be accepted by graduate programs throughout the country. Therefore, during the Denver meeting we devoted our

efforts to examining the current status of graduate program education under the broad area of health services administration and how the needs of educating administrators of MR/DD and similar multidiscipline type programs could best be met.

The outcome of all this planning to date resulted in the publication of the position paper which you should have received last summer. The initial publication of the position paper did not clarify the purpose of its publication and there seemed to be some confusion regarding its recommendations. In answer to these questions the committee decided to revise it and this resulted in the publication of a revised edition, copies of which are available here for each of you. As stated in the preface of the position paper, it is intended to serve as an initial working document on the subject matter of graduate education for administrators of mental retardation/developmental disability programs and institutions. It can and should serve as a focus for discussion and debate by educators, administrators and executives of agencies and organizations. From these discussions, specific actions can be taken to further develop educational programs in this field. The advancement of such educational programs is the overwhelming objective behind the publication of this document. Hopefully, the discussions during the next two and one-half days of this conference will further the development of educational programs in this field.

The position paper is only one-half of the overall effort of our committee's objectives. The other half deals with continuing education of those administrators already in the field. The continuing education report which has been finished but not printed yet was a joint effort between our committee and a subcommittee of the Task Force on Mental Health and Mental Retardation Administration chaired by Vic Keeran. Vic will be giving you a progress report of this committee's efforts tomorrow morning.

The concept of administrators as educators is an important one, but the realities of available time and doing justice to both the function of being an operating manager and a teacher to educate administrators in this field are very difficult. Hopefully, the results of this meeting will suggest some possible solutions to this dilemma. Wil Clouse has done an excellent job in setting up the format of this conference. I look at the three models which we will be discussing today as three levels of involvement at which we, as administrators, can become educators. Hopefully, our discussions will clarify in your mind the level at which you wish to be involved.

ADMINISTRATION TRAINING IN THE UAF CORE CURRICULUM

Moderator

Melvin Peters
Child Development Center
University of Tennessee

THE IMPORTANCE OF ADMINISTRATION AS A SUBJECT IN A UAF CORE CURRICULUM

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Introduction

To meaningfully address the topic of administration as a subject in the core curriculum in University Affiliated Facilities (UAF), it is necessary to review the purpose of the core curriculum, and make some observations about the subject matter of administration. The benefits that might be expected from inclusion of this topic in the core curriculum will then be discussed.

The Core Curriculum

The primary purpose of the core curriculum is to provide all UAF students, regardless of discipline, with a common body of knowledge about mental retardation and developmental disabilities. Topics covered generally fall into four basic areas: first, definition of developmental disabilities, characteristics of affected individuals, causes of conditions resulting in developmental disabilities, epidemiology, and issues of definition and classification; second, methods of evaluation and diagnosis, client needs, family needs, major forms of intervention, and the role and characteristics of primary care providers; third, service delivery systems--a conceptual model for a comprehensive system, characteristics of coordinated systems, characteristics of unified systems, "typical" systems, components of the system, including patient-oriented services, and the role of consumers in the development and governance of services; fourth, societal hazards to the developmentally disabled. These sessions include descriptions of frequently held attitudes about the developmentally disabled and the resultant tendency for them to fare poorly in usual civil rights. Means of

remedying these inequities including advocacy, public education, judicial findings, and new legislation are considered.

With this overview of the core curriculum in mind, it is timely to review some of the subject matter of administration.

Administration

The profession of administration as applied to developmental disabilities (DD) consists of a body of knowledge and a set of skills which fall within three broad categories: (a) the design and utilization of social systems, (b) understanding and working with individual and group behavior in organizations, and (c) management of resources. Each of these topics will be described briefly.

Design and utilization of social systems. I elect to refer here to social systems in lieu of the more traditional term "organization," since we often deal with organizations in a broader sense. This category is comprised of all activities related to planning, establishing goals, setting priorities, and defining the purpose of the agency. Organizing, delineating areas of responsibility, and defining communication networks are included. It is also necessary to establish means of cooperation, coordination, and linkages both internally and externally. The pattern of governance and other mechanisms for monitoring changing demands on the organization are important. All issues pertaining to the service delivery system and the role of consumers are a part of this function. The role of the consumer and the service delivery includes all of the techniques for achieving change within a system.

Influencing behavior within organizations. Since administration is a "process" of getting things done through people, this general category includes knowledge about styles of leadership, supervision, methods of problem identification, problem analysis and problem-solving, methods of establishing performance standards and performance evaluation, conflict resolution, and all of the

techniques of employee development and employee relations.

Resource management. The elements of resource management are most often associated with the role of the administrator. They include budgeting, accounting, information systems, workload standards, technical aspects of personnel management, purchasing, space utilization, and a definition of systems and procedures.

In reviewing the topics of administration and core curriculum, it becomes readily apparent there are substantial areas of similar interest. Therefore, it is timely to discuss the relationship of administration to the core curriculum.

Why Should Classes on Administration Be Included in the Core Curriculum in UAFs?

A symbiotic relationship exists between administrators and the care rendered by primary practitioners. Perhaps the nature of this relationship becomes clearer by use of an analogy. An individual may spend years learning to play the violin, become a concert violinist, and perform as a soloist. However, more often than not, the musician's skills will be practiced in conjunction with others, i.e., as a member of an orchestra is composed of many musicians playing various instruments. The sum of their collective efforts produces a very different result from that of a random collection of soloists.

Similarly, the physicians, social workers, psychologists, and others who participate in the interdisciplinary program of a University Affiliated Facility may someday enter private practice. However, more often than not, they will practice their discipline within the context of an interdisciplinary program. Insofar as the administrator is responsible for addressing the issues of how individuals with varying skills come together to produce a desired result, the position of the administrator parallels that of the single musician. The conductor may have formerly played an instrument or still retain those skills but the role of conductor (administrator) requires a different set of skills.

This analogy illustrates the relationship between the individual practitioner, interdisciplinary practice, and the role of administrators in relation to the total activities.

The interdependent nature of the administrator and primary care personnel is clear. The administrator is nothing without an organization, and most practice occurs within the context of that organization. The nature of this relationship must be understood by the administrator and the primary care providers if they are to work effectively together. A step toward this understanding can be taken by including sessions on administration in the core curriculum.

Administration in the core curriculum should help clinical disciplines or practitioners to participate more effectively in developing beneficial configurations, policies and procedures. Individuals within a group may be preoccupied with developing their own skills. However, sooner or later, they will become aware of the fact that the organization serves to either facilitate or impair their practice. In the administrative portion of the core curriculum, future practitioners should start developing their skills for identifying problems and helping the organization find solutions which facilitate rather than impede clinical efforts.

Certain topics in administration have cross-disciplinary application. For example, some of the techniques of planning such as management by objectives, methods of problem identification, and problem-solving can serve to sharpen clinical skills. There are many similarities between the problem-oriented record and techniques for problem identification and problem-solving in organizations.

Administration in the core curriculum will, for certain individuals, be an introduction to administration. During the short history of the UAFs, there is considerable evidence that a number of graduates have been promoted rapidly. Demands of an administrative nature are being made upon them. In other words,

many of the graduating students will, sooner or later, move into roles of administrative responsibility. The administrative portion of the core curriculum should at least provide an overview of the knowledge and skills required of an administrator so that the unsuspecting clinician can start preparing for that role.

Participation in the core curriculum benefits the administrator. Practicing administrators rarely have to formalize their concepts and provide the rationale for their role, functions and styles of administration. Teaching in the core curriculum requires an administrator to formalize his thinking. This exercise often results in refinement of concepts and consequent improvement of practice. Therefore, improvement in performance is a potential benefit to the administrator.

In summary, the core curriculum is a means of assuring that student participants in UAFs have a common body of knowledge about the field of DD. This paper strongly urges that classes on administration should be included in the curriculum: (a) to foster effective communication between administrators and participants, (b) to enhance participation by clinicians in the formation of organizational practices, policies and procedures, (c) as an introduction to administration for clinicians who will ultimately become administrators, and (d) to sharpen the thinking and practices of the administrator.

CORE CURRICULUM ADMINISTRATION PROGRAM:

A UAF MODEL

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University of Colorado
Medical Center

Introduction

As indicated on the program, I am currently serving as the Acting Director of the University Affiliated Facility (UAF) in Denver. Although I am the Acting Director of the UAF, my presentation will be from the standpoint of a full time administrator. During the next few minutes I would like to describe the core curriculum program as it is currently constructed in our UAF at the Colorado Medical Center. Our core curriculum administration project is an actual model in process. The model, like many other UAF models, is not yet fully grown. The UAF model in Denver is somewhat unique because of the interesting way in which it originated and has continued to grow over the years. The program has grown from a minimal amount of input from the administrator in administrative theory to the point of developing a formal part of the core curriculum.

Administrator Influence

At the time that I became a member of the Kennedy Center as the Administrator, the UAF was already a well-established organization with every discipline represented with the exception of administration. The Kennedy Center had never had an administrator during the early developmental phases. It had been administered by a director who admittedly had no administrative background and realized his vulnerability. The director was assisted by an administrative assistant who was primarily concerned with the day-to-day operations of the Office of the Director. No one had given any thought to the development of a program that would engage trainees in the field of administration. The core curriculum for the UAF had

already been established upon my arrival and each trainee was committed to a full academic program. The UAF program is uniquely located on the Colorado Medical Center campus which gives it immediate access to the School of Medicine, the School of Dentistry, and the School of Nursing. The Division of Health Administration, a graduate degree program for health administrators is also located in the School of Medicine. This unique organizational structure has made it possible for the UAF to move quickly into core curriculum programs for administration. The availability of qualified faculty members in health administration through the Division of Health Administration has provided an excellent opportunity for consultative and collaborative interfacing.

Now that you have some idea of the organizational relationship of our UAF to the Medical School, I would like to outline my experiences as the UAF administrator in the core curriculum administration program. When I entered the UAF program there was a general feeling that the UAF staff had a distrust or a lack of appreciation for administration. Frequently I heard the term "administrative trivia" used in relationship to administration. As many of you know, I moved to a UAF position from a central medical center administration position within the Medical School. Some UAF staff members had the feeling that I had been sent in as a spy. As you can imagine, I was immediately placed in an extremely difficult role. The positive aspect of my new position was that the director realized that he desperately needed help in the area of executive administration and he gave the administrator practically a carte blanche ticket to develop effective administrative systems. Now, how do you proceed in a situation like that? Well, at first I did nothing except to observe and analyze and quickly realized that the center was without good administrative and management practices. The ineffective administrative systems in operation at the center were also having an adverse effect on the trainees as they passed through the UAF program. With these two basic observations I decided that the best way to teach management systems in this environment was to teach by example. So, I

began to attend all training sessions and to take an active part in the discussions. I gave suggestions, ideas, and proceeded to change management practice within the center by management by participation. It turned out to be rather successful. I wanted to prove that effective management could be implemented in the center and I wanted general acceptance from the staff. For quite sometime I continued to implement, wherever possible, effective management and administrative systems. I decided not to force my way into the core curriculum at this time. I think it would have been a disaster and a suicide on my part to have forced administrative courses into the core curriculum. Eventually, I was asked, as the administrator of the center, to prepare several sessions on grant preparation. This was still very informal and not incorporated into the core curriculum. However, with this invitation I was able to provide input into areas such as planning, budgeting, legislation, personnel administration, affirmative action, and other relevant subjects. About the same time, I applied for and received a faculty appointment in the Division of Health Administration. After I received the faculty appointment I participated actively in all faculty meetings and in curriculum development. I did not participate in the formal graduate courses conducted by the Division of Health Administration, but I did participate on committees and developed short courses which were more of an informal nature than the structured curriculum. This gave me a chance to become acquainted with all of the faculty members in the Division of Health Administration and to learn of their interests in UAF administration. As the opportunity presented itself I began to invite faculty members from the Division of Health Administration to visit our UAF center and to present selected lecture series on such topics as future trends in health care organizations, decision making, motivation, program evaluation and accountability, a problem-oriented medical records system, and other needed topics. This involvement led to the development of a 12-hour instructional program in health care administration.

Summary

From this type of a beginning, we have been able to utilize a large number of faculty members from the Division of Health Administration in the development and implementation of a core curriculum program in administration. While this process may seem pretty slow and pretty laborious, I think, in my situation, it was the only way to develop an awareness of the need for administration. Our UAF is now ready to develop a formal core curriculum administration training program. This approach has also taught me that a full-time administrator cannot be totally responsible for conducting and implementing all training programs within the UAF. In our situation at Denver, we were fortunate in having a Division of Health Administration available on our campus. The faculty in this division has been extremely helpful in establishing the right type of rapport with staff members in our UAF and also with trainees. If you are not fortunate enough to be on a campus where there is a facility in administration you must look elsewhere. I would suggest that you look at the possibility of using faculty members from the School of Business, and other schools of health administration. We have made a great deal of progress at our UAF in Denver. I have actually found that the trainees and staff members are now coming to me and saying, "I heard the neatest lecture last night. I wonder if you could arrange for this presentation to be presented to our staff. It is tailor made."

The model that I have presented is only one approach to introducing administration into the UAF core curriculum. I has worked very effectively for us at Denver and it may possibly apply to your particular UAF.

THE ROLE OF THE ADMINISTRATOR IN THE CORE CURRICULUM ADMINISTRATION PROGRAM

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The University Affiliated Facility (UAF) administrator's role in the core curriculum administration program, as I perceive it, involves five basic elements. Recognition of these five elements and their implementation should contribute significantly in developing and maintaining an effective program. These five elements are discussed below.

Leadership

First, the administrator should provide the leadership and take the initiative to establish the concept of the need for improved, administrative management. Although there are some UAF directors who will provide strong leadership for improved administrative management, most will probably tend to be preoccupied with their broad leadership role or with their particular field of professional interest. The UAF administrator, therefore, must take the initiative to establish the concept that administrative training will be of benefit and value to the trainees as part of their overall training experience.

The administrator must combat the lethargy inherent in most organizations which tends to minimize the need for "administration." Frequently, administration is an unpopular and depressing concept. It is often regarded as "something the clerks do with the budgets," or to those people who handle personnel, plant and equipment maintenance, purchasing, etc. instead of people who have to concern themselves with what are perceived to be much more important matters directly related to our society's social problems. This lethargy exists particularly in universities because of the

much greater emphasis placed by academicians on resolving the real problems of the world through their specific discipline. It is necessary, therefore, to impress the UAF director and the other UAF faculty with the need for an administrative training program. Obviously, the need should be expressed in terms of the preparations of trainees for assuming their professional roles. In addition, it is extremely helpful to gain the general support of the university. Operating in a climate or atmosphere in which the need for administration training is recognized and generally supported will enhance the administrator's leadership role.

After gaining the support of the UAF director, other UAF faculty, and the broad, general support of the university, the next important step is to secure the commitment of necessary resources to support the program. These resources might be in the form of student stipends, faculty time, allocation of trainee time to administration training, and any other necessary commitment of resources to successfully operate the program.

Because of his role in the UAF, the administrator is in the best position to provide this leadership. This is his area of expertise and should be a natural function for him to perform.

Liaison Relationships

The second basic element involves establishment of liaison with the appropriate university, school, college, or department concerned with academic administration training. The facility with the most appropriate academic objectives related to administration of UAFs should be identified. This may be, for example, the School of Public Administration or the Graduate School of Management. At the University of Washington, the Department of Health Services of the School of Public Health and Community Medicine is the most appropriate entity, although interest in the field has also been expressed by the Graduate School of Business Administration. In any event, it is

necessary to identify and establish an affiliation with the appropriate academic entity most pertinent to administration training. The principal purpose is to gain the credentials and accreditation of an academic entity concerned with administration training.

Specific faculty or, if possible, the departmental chairman of the academic administration training entity should be next identified and contacted with a proposal for affiliation. The advantages to the department should be indicated and negotiations for the department's involvement and commitment to UAF trainees should be carried out until some mutually satisfactory agreement is reached. The advantage to the academic department would be the opportunity for involvement of their students in UAF activities. In other words, the UAF provides a resource advantageous to the department.

As the relationship between the UAF and the academic department develops, it is extremely important that, if possible, a faculty appointment in the department be secured for the UAF administrator or other representative of the UAF concerned with administration training. Conversely, it is important that departmental faculty members interested in UAFs secure appropriate affiliation or recognition by the UAF. The academic department should formally recognize the UAF and the UAF should formally recognize individual faculty members from that department.

Partnership Relationships

The third basic element involves the establishment, in partnership with the academic expertise provided by the department, of a course outline in administration training. The objectives of the course should be carefully developed. An important factor is to determine the time available to UAF trainees to participate in administration training in balance with other training requirements. Course content should be developed with priority

being given to the inclusion of subjects such as basic management and organization theory, planning, accounting and financial management, small group dynamics and interpersonal skills, and community politics and inter-organizational decision making. The joint development of course content by the administrator practitioner and the academic faculty member should be encouraged. Particular emphasis should be given on the need for models of learning based on mutual participation of faculty and practitioners.

Teaching Process

The fourth element concerns the participation of the administrator in the teaching process. The administrator brings an important dimension to the teaching process in the sense that he should relate the unique inter-disciplinary team approach characteristics of a UAF to the curriculum. The unique aspects involve the greater external environmental relationships usually present in UAFs, and the difficulty in measuring outcomes.

The administrator should also be in a position to involve other qualified practitioners in the teaching process. For example, a hospital administrator could participate in particular areas of his expertise in some of the training. Presentation of UAF case studies might be provided by the administrator. In addition, the administrator may provide for practicum experience in administration for trainees, if appropriate.

Within the relatively short time available for administration training to UAF trainees, perhaps the principal objective of the teaching process is to emphasize the need for continuing education in management improvement. After entering into their professional careers, most trainees will, within a relatively short time, become directly involved in administration as supervisors, program managers, or part-time administrators within their own specialties. Further education in management techniques will be invaluable to them. It is important that the administrator constantly stress that managerial skills are and always will be in great demand.

Advocate

The fifth element is the concept that the UAF administrator must serve as a continuing advocate of the need for effective management and its implementation. We are in an era where there is continuing and increasing emphasis on limited resources and their effective utilization. Cost effectiveness, accountability, management by objectives and similar terms are becoming commonplace concepts that everyone should become familiar with if they are at all involved in any organized effort. The managed system approach to the solution of problems will be of the utmost importance. Earlier concepts of management by intuition of the leader are no longer acceptable. Planning and systems management are terms that are now accepted and, in fact, usually required in any effort involving organizational support.

Basic administration training, therefore, becomes a necessary part of the education and training of anyone preparing for a working career. Too often this concept is not well understood or fully appreciated. The UAF administrator must constantly work to promote an understanding of these concepts.

PRECEPTOR-INTERN RELATIONSHIPS

Moderator

R. Wilburn Clouse
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PRECEPTOR-INTERN RELATIONSHIPS IN ADMINISTRATION TRAINING

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Introduction

It is a pleasure being with you today and a special pleasure to learn that you, in your capacity as administrators, have a desire to also be educators. But then this should not be so surprising. By definition, administrators are leaders. The latin roots of the word education (educere) is "lead out." Administrators, then, are educators.

But definitions alone would not make it so. Administrators today must be concentrating a generous amount of his/her time in the development of his/her staff or an important part of management will be neglected. Administration, it seems to me, is not only the application of learned knowledges, skills and behaviors, but is also a process whereby one's associates--be they subordinates or superiors--are guided in the acquisition of administrative talents. So it is with preceptors.

The University of Minnesota's Program

A wide variety of preceptor models exists. Before getting into my assigned subject "Preceptor-Student Relationships in Administration Training," permit me to describe a program I am currently associated with which requires one distinct type of model.

The University of Minnesota's program in mental health administration training is within the University's School of Public Health and is part of the program in hospital and health care administration. Seven to nine students are selected each year for this mental health track and spend one year (10 months) on campus in academic study and then are assigned to a preceptor for a period

of 11 months. Residencies (internships) are in a mental health facility. This special program is in its third year and is funded by the National Institute of Mental Health for a period of five years.

The objectives of this experimental program are:

1. To develop innovative and knowledgeable leaders in mental health administration through a training program which responds to the needs of the field.
2. To identify the components of the practice of mental health administration as shifts occur in the system.
3. To explore the appropriate knowledges, skills and attitudes which are relevant to the training of administrators.
4. To experiment with methods of assisting students in learning the effective practice of mental health administration.
5. To establish a system of feedback to evaluate and modify the program as it evolves.
6. To attempt an identification of those personal qualifications that enhance the probability of effectiveness in the practice of mental health administration.

Several of these objectives may be somewhat idealistic and debatable. They do, nevertheless, offer guidance in providing a pathway for outcome expectations.

Accepted students attend an A. K. Rice Institute Group Relations Conference prior to the beginning of the fall quarter. This 1-week experience, an intensive exploration of organizational authority, has provided the entering students an opportunity to begin their collective educational mission together.

All master's degree students are required to take major areas of on-campus study consisting of: (a) general management, (b) human relations, (c) statistics and quantitative methods, (d) financial management, and (e) health systems and environment. Previous academic work in any of these knowledge areas may permit

the student to enroll in other course work. Students are assigned to preceptors in the Twin City area during the first year and apply their academic learning to real and existing administrative problems. For the mental health administration students, these assignments are in a mental health setting.

Some course work is designed specifically for the students in this special track and includes: Mental Health/Mental Retardation Facility Financial Management, a seminar which focuses on related literature, experiences, issues and applications, and a legal aspects course. A total of 70 quarter credits is required for graduation; 12 of which are awarded for successful completion of the 11-month administrative residency.

Of vital importance to the total training of the student is the administrative residency (internship) which begins early in August and is concluded at the end of June at the time of graduation. The formal matching of students with preceptors and facilities is a somewhat involved and complicated process which begins toward the end of the fall quarter. (Experience indicates that informally the process probably begins with the student shortly after the student is notified of acceptance into the program.) Students are requested to describe their 5- and 10-year career objectives in writing. The results of this assignment is helpful both to students and faculty in assuring a more systematic approach to this important aspect of the training. Most frequently cited objectives include references to: front-line management positions, planning-type jobs, federal, regional or state central offices, as well as proprietary, nonprofit or employment in the public sector; interest in an institutional or an out-reach community service setting is usually identified along with the type of constituency the future administrator desires to work with such as: the developmentally disabled, the mentally ill, mentally retarded, the chemically dependent or a combination of several or all of these disability groups.

Following this exercise, the student and faculty discuss the student's

previous training and experiences with the residency assignment in mind. If the future administrator comes from a clinical background such as psychology or social work, then it is frequently indicated that a preceptor who has been trained in administration might (but not necessarily always) be considered.

Of considerable importance for consideration are the personalities of the student and the preceptor. How will they mix? A student who needs continuous and straightforward feedback about his or her performance will hardly prosper educationally with a preceptor who is reticent to do so. Such a situation would only lead to a frustrating and a less than full and rich educational experience.

Once these considerations begin falling into place, the student's personal needs begin surfacing and, of course, must be dealt with. Where is the facility located, is it rural or urban? Will it be difficult for my family to find a place to live? Can we survive financially? How much will the facility pay? For unmarried students, romantic possibilities are not forgotten. Is there a possibility of future employment with the facility or in the area? Will we have to move again?

Selection of Preceptor

The key person in a successful residency is the preceptor. To accommodate the variety of learning experiences students request, it is necessary to have about 15 preceptors for eight or nine students. This means, of course, that in some years, several of the preceptors will not have a student assigned to them. Preceptors are selected first and foremost on their demonstrated administrative track record. Following this requirement, the preceptor must be willing to participate in an educational venture by alloting time in his/her schedule to prepare the total organization for the student's learning process as well as actually spending time with the student. All centers of activity must become available for incorporation into the educational process if the

student is to have an understanding of the total organization and the systems by which it functions. One of the more commonly (and successfully) employed methods of organizational exposure is the "project" assignment. That is, a meaningful project is assigned the student which has relevance to the organization, is within the grasp of the student and will require information gathering from many parts of the organization.

Some would attach considerable weight to the credential the preceptor carries. While the importance of credentials cannot be denied in our society, this writer feels that an impressive administrative track record and the willingness to participate provides the best base for the "role model" desired. If these attributes are in place and a credential happens to go along with them--so much the better.

One might describe the relationship between the student and the preceptor in some of the more traditional (and well-worn) words such as: trusting, open, honest, loyal, on and on ad nauseam. While there is nothing wrong with all that these words connote, they lack substance in defining a relationship applicable to an educational process between two people. A much more valuable method of spelling out these relationships is known as a Mutual Expectation Contract. This contract is merely a verbal agreement of the behaviors expected in the relationship between two people. The development of this contract is best done during the early phase of a relationship (after a period of orientation to the facility and staff), and as a contract between two consenting adults. For an example, the preceptor might request that the student first write out his/her learning objectives for the year. These might include: to have an in-depth understanding of the financial affairs of the facility; to be able to arrange and conduct a meeting with the top executive group; to make a verbal and written report to either internal or external personnel and to receive a critique of his/her performance; to understand how governance of the facility is structured and how the process occurs.

The preceptor, then, with the student agrees upon how each will implement these learning objectives. The student may well expect the preceptor to permit the student to make a mistake, but then assist the student in benefiting from the mistake so that an opportunity for growth and development has actually occurred. The preceptor, on the other hand, could rightly insist that the student respect the confidentiality of their relationship. The preceptor might well share feelings and attitudes with the student which would not be available to any other members of the staff. As such the student must respect that that information is given to assist the student in his/her development and not as idle gossip. This model--the Mutual Expectation Contract--then, spells out rather specific desired expectations thus eliminating the descriptive vagueness often found in such words as trust, openness, etc. Once established, (though alterations should and must occur from time to time) the contract can provide the basis for a continuous building of the tutorial relationship.

The role of the preceptor can now shift to that of a facilitator of the integrative process. Dr. William G. Hollister, in an unpublished paper "Integration Units for a Curriculum on Mental Health Administration," describes this role as a consultative relationship rather than as a general supervisor. Eliciting motivation through use of the student's goals and methods of periodic measurement is a better tool than "you ought to" messages.

"Goal setting for the tutorials," states Dr. Hollister, "needs to be dynamic and continuous.... It avoids the use of glittering generality existential gap creating goals...." This causes the preceptor to ask of the student, "How can you humanize your control and monitoring activities, so your staff does not feel you are spying on them" rather than "you ought to." Providing opportunities for the student to "reintegrate his set of values in the light of all the new knowledge and experience inputs he/she is receiving" is a key function of the preceptor. To develop and utilize this integrative skill truly distinguishes the administrator in his/her educator role.

THE ROLE OF THE ADMINISTRATOR AS A PRECEPTOR:

A PRACTICAL EXPERIENCE

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Introduction

My assignment at this conference is to describe the role of an administrator as a preceptor in preparing newcomers for careers in our field. I view this training responsibility as one of the ongoing professional duties of a currently employed administrator. It has been noted that academia alone cannot be expected to produce a mental health administrator as a finished product[1]. The same can be said for a health research administrator and consequently some form of tutorage is required.

An excellent method of training for our field is by a practice experience undertaken in conjunction with didactic work. Such practica are identified in various ways. They might be called preceptorships, internships, residencies or by other designations. What is characteristic of all of them is that they are usually nonsalaried, although there may be training stipends, and the trainee is expected to use the experience for learning and not to fill a position for which he or she is already qualified.

A Practical Experience

The trainee I will describe is a woman who had worked as a bookkeeper and office manager of a small residential institution. It was her intention to obtain further training in health or research administration so that she could function at a higher level with greater professional competence.

Concurrent with her 6-month period at our center, she was taking academic courses in sociology and in current social problems. Her placement with us was considered as an independent study course. She was to receive academic credit on completion of a paper describing her assignment and which was to include a critique of her activities as an administrative trainee.

In our initial contact it was decided that she would be given one or two major and specific responsibilities which she could handle independently. These would be in contrast to her dealing with a large variety of small tasks where she might have superficial contacts with our program activities and personnel.

During her half-year placement she worked between 1½ to 2 days per week. One of her assignments was to develop a uniform program information system for personnel in the 12 mental retardation research centers. I was a member of a committee charged with preparing guides for obtaining data about the number and categories of personnel employed in these centers. Consequently, this assignment was recognized by her as being meaningful and essential to the effective administration of our program.

Using some earlier data as a beginning, the trainee reviewed several reference sources dealing with manpower information. She then developed a system of classifying our personnel into three categories: administrative, scientific professional and scientific supportive, and established criteria for the assignment of positions into these categories. Following this, she personally contacted each of the 30 different programs in our center and interviewed either the principal investigator or the unit administrator. This experience provided her with a chance to deal directly with our key scientists and to get a thorough orientation as to the nature of their personnel and their job expectations of their employees. She learned to understand the multidisciplinary nature of our center and how our staff engaged in interdisciplinary work.

Her final report was extremely useful to us and was accepted as an initial step in establishing a reporting system for the Mental Retardation Research Center Branch of NICHD.

She also undertook a consolidated study of the program funding for each research activity in our building. For this report, also required by NICHD, she obtained information about each award, its source and the duration of its funding. In this instance she again visited each program in order to obtain detailed information.

In all of her work assignments, she proved to be an extremely conscientious person who did outside reading related to her assignments. Each week we had tutorial conferences from 1 to 2 hours in length. At these meetings we would discuss related administrative matters which she had observed in her contacts in the building. Based on suggestions growing out of the First National Conference on Education for Mental Health Administration, we also discussed several topics which should be part of an administrator's erudition[2]. They included financial management, grantsmanship, decision-making processes, problem solving, organizational politics, interorganizational relationships, public relations and community affairs. As a result she obtained a well-founded picture of the diversity of issues which confront an administrator.

As the weeks passed, our discussion and her experiences concentrated more on general management problems rather than on her two projects. For example, she asked to read new grant applications and attended a meeting called by the College in anticipation of a possible strike by our union employees. She was also encouraged to attend seminars and grand rounds to gain greater insight into some of the scientific subjects being investigated.

In reviewing her work at the end of her placement, she agreed that having had complete responsibility for two specific studies was a rewarding educational

experience. Her projects were essential to the effective operation of the center. She felt that she had offered a service to us, at the same time as she was enhancing her understanding of administrative processes and her own skills. She commented that one of her fellow students had a placement elsewhere in which she had been given a variety of minor tasks and created assignments. This other student viewed her traineeship as a less productive learning experience. She also sensed, because of the low level of her responsibilities, that she was not trusted to do significant work. Her duties had been inconsequential, this other trainee believed, and did not reflect the type of decisions that administrators are required to make.

It is my recommendation that students in administration should be given important tasks that are essential to the organization and which develop their problem-solving capabilities. It is only by manifesting confidence in the potentialities of our trainees that we can foster their independence and skill.

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[1] Feldman, S., & Cahill, P. A. Administration in mental health, Vol. 3, Fall, 1975, p. 89.

[2] First National Conference on Education for Mental Health Administration, New Orleans, March, 1975.

ADMINISTRATION DEGREE PROGRAMS:

UAF AND UNIVERSITY RELATIONSHIP

Moderator

Jerry Elder
University Affiliated Facility
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INTERDISCIPLINARY EDUCATION IN HEALTH SERVICE ADMINISTRATION

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Introduction

The changes that have taken place in the organization and delivery of health services during the past decade have dramatically changed the role of the administrator. These changes correspondingly have placed new demands on graduate education in health administration and have increased the needs for interdisciplinary programs. This paper will briefly trace the changes in health care delivery and administration, comment on the effects of these changes on graduate programs in health administration, and identify some of the emerging educational patterns.

Small Organizations--Generalist Administrators

Until recently the health care field has been characterized by small scale organizations. Physicians set up private practices in neighborhood offices, often alone or with one partner and some office help. Pharmaceuticals were distributed by the small corner drugstores, and the one man dentist office, the small hospital and the family-owned nursing home dominated the field.

These small scale organizations placed few demands on administration and administrative functions were often carried out on a part-time basis by health professionals. Hospitals represented virtually the only large organization in the field and hospital administration was for many years the only well defined and recognized administrative role. Even as such, the professional dominance of the organization and the limited role of the administrator caused them to be coordinator/facilitator generalists rather than true chief executive officers.

Correspondingly, graduate education in health care administration (or more accurately, hospital administration) at that time was general in nature. The master's degree programs were relatively short with general course work which had little theoretical foundation and required a relatively long hospital residency. There were also a few public health administration programs but they were heavily oriented toward public health practice and provided, in most cases, only one or two courses in administration and were directed toward physicians wishing to direct health departments.

Changes in Health Care Delivery and Administration

In recent years, the health care system has changed dramatically. First of all, medical technology has, and continues to, expand rapidly, increasing expectations of consumers and producing a wealth of new types of health professionals. The near miracles of yesterday are now commonplace and are, in fact, demanded by patients. The complexity and high cost of this expanded technology has increasingly shifted the provision of services to large scale organizations that have the administrative ability and financial base to cope with these demands. The new types of health professionals, e.g., radiation physicists, computer axial tomography technicians, etc., were in fact spawned by the expanding technology and generally became part of large organizations--in most cases large hospitals. Health professionals that have been in existence for some time are also becoming more specialized in response to the changing knowledge base and similarly are now frequently based in large organizations. While hospitals were once virtually the only organized entity in the field, there is now a proliferation of organizations including a rapidly expanding number of medical and dental group practices, HMOs, health planning agencies, and specialized organizations such as UAFs. The new types of health professionals, the expanding technology and the equipment associated with these changes have drastically increased the total expenditures for health care.

This, of course, is exacerbated by the rising expectations created by the "right to access to quality health care" public policy.

Congress has reflected these pressures and expectations in a statement of priority: "The achievement of equal access to quality health care at a reasonable cost is a priority of the Federal Government" (P.L. 93-641). This statement of priority is part of the National Health Planning and Resources Development Act of 1974 which is only one of a number of recently passed health care bills, e.g., PSRO, Health Maintenance Organization Act, Emergency Medical Services Act, etc. These new regulations have created a whole series of new organizations and new stresses on the existing system.

As a result of these changes, small organizations with fragile administrative structure and capabilities can no longer function. New organizations are rapidly developing to take on additional roles, larger delivery organizations are forming to integrate a large variety of services, and more and a greater variety of health professionals now are practicing within these organizations.

The demands upon health administrators in this setting is significantly different from that of the past. Administrators in this setting must have knowledge and skills that were not needed 10 to 15 years ago. Not only must administrators be knowledgeable about a greater range of health services, but they must also have more specific skills such as information systems, computer science, financial management, etc., in order to deal with the complex problems engaged by their role. The generalist--facilitator/coordinator--finds it difficult if not impossible to function in this manner and is often not competitive in the job market.

Graduate Education

Graduate education in health administration reflects these changes in the health care field and the corresponding changes in the demands upon

administrators. Many of the graduate programs have moved away from the generalist approach and are devoting much more time to the skill areas. There is still a series of courses in general administration, but there are also courses in financial management, planning, marketing, and similar functional areas. Programs are attempting to give their graduates specific skills that can be used at the entrance level yet provide the broad management orientation that will enable the graduates to move up to the chief executive officer level in a wide variety of health care organizations.

Increasing the course work in specific skill areas requires more didactic time than the generalist approach. Many programs have responded to this by reducing the length of the residency requirement and by reducing or eliminating the courses devoted to a particular environment, e.g., the hospital or nursing home. Increasing the specific skill area requirement has also changed the needs for interdisciplinary education. The current demands cannot be met with a narrowly oriented or skilled faculty. A faculty for graduate education in health administration must now have diverse skills and diverse backgrounds. Many health administration faculties now include backgrounds in organizational behavior, planning, general management, public health, medical science, financial management, economics, and political science.

Most graduate programs have always been interdisciplinary in that they brought together the business and management disciplines with public health and medical science faculties. The further development of this interdisciplinary faculty has occurred along two general dimensions--again responding to the changing field. First, the response to the functional management needs of the field brought faculty with planning, finance, marketing, and organizational behavior to the programs. Secondly, the rapid development of a large variety of organizations in the health field and the expansion of the administrative roles in those organizations caused graduate programs to add faculty with disciplines co-lateral to administration but important to those organizations, i.e., demographers in

programs preparing administrators for planning agencies. A third, and somewhat less defined interdisciplinary dimension developing in graduate programs, centers on the provision of administrative course work for physicians, nurses, and other health professionals who wish to become better prepared for their administrative roles at the patient care level. This includes team management at one level and, on a more general level, program administration either within an organization or as a separate entity. Graduate health administration programs involved in these teaching efforts are adding faculty to bridge disciplines, i.e., physicians who are clinically active but also understand administration and are conversant with the management discipline.

In order to accommodate these changes, graduate programs in health administration have engaged a variety of educational formats. Most have altered their traditional 9-month academic and 12-month residency format expanding the academic portion to 12 months (and increasingly to 18 months) with a concomitant reduction in the field experience. Most graduate programs are also broadening their scope of activities and are changing their names from the traditional hospital administration and public health administration programs to health services administration. These changes are often followed by a diversification of the faculty and the development of field experiences and residencies in a broad range of organizations in the health field. To facilitate the development of content material in the functional areas of management many programs have developed relationships with schools of business. In some cases, this has led to a co-sponsoring of the graduate program between schools of public health and business or medicine and business. The shortening of the residency period has also caused programs to develop different relationships with the field of practice. Field projects integrated into the academic program and the development of more structured and intensive field experiences have evolved to compensate for the loss of the 12-month residency. Many programs are also considering management development programs similar to that used in other

industries. Large organizations in the business field have, for example, traditionally hired new MBA graduates into a management development program for their company fully expecting that many would eventually move to other organizations. A program such as this in the health field would help bridge the academic and practical aspects of the program and would greatly enhance the program's ability to develop a life-long learning approach. In the past, few organizations of sufficient size existed in the health field and this approach was therefore limited. In the future, however, with the development of larger organizations, this may evolve into a highly successful way of integrating academic and work experiences at the graduate level.

Summary

The field of health administration is changing dramatically both in terms of role expansion and in the diversification of role types. Graduate programs in health administration are changing concomitantly and are developing expanded broad based interdisciplinary educational programs to meet the needs of this changing field. In most cases the graduate programs are quite responsive to the needs of the field and the graduates are seeking entry level jobs in a variety of health care organizations.

In many ways, the bridge between academic programs and the field of practice is built on residencies, field projects, and summer field work experience. These experiences serve to acquaint students with specific organizations and agencies within the field and help them form their career objectives. Programs differ considerably in terms of how they structure these field experiences and conduct this portion of the educational program. Most programs, however, pursue some type of field experience and regardless of whether it is based on projects within academic course work or on a 12-month residency, it provides one of the most promising reference points for organizations such as UAFs to articulate with the graduate programs and attract graduates to their

specific fields. This approach will, I believe, serve UAFs and the entire field of mental retardation far better than attempting to develop specific graduate programs for that field alone. The resources necessary to carry out quality interdisciplinary education at the graduate level make it extremely difficult for programs to acquire those resources to prepare graduates for one specific organization or agency within the field. A program made up of one or two faculty members cannot hope to provide the graduate education demanded for today's field of practice. Finally, I believe that you will find that health administration graduates will bring a broader perspective to your field and will be far better prepared to deal with the many health systems issues that must be faced by all organizations within the field today.

A MCHS APPROVED ADMINISTRATION PROGRAM

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During the next few minutes I would like to outline a series of events that led to the development of our approved administration program at The Nisonger Center at Ohio State University. The impetus for this administration training program began in late 1968 or early 1969 when I received a phone call from Jim Papai concerning the establishment of some type of an administrative experience in health services administration. The interest at Maternal and Child Health Services (MCHS) surfaced at this time due to a request from an individual for such an administrative traineeship. The person requesting the traineeship was contacted and he ultimately visited Ohio State University to determine whether or not such a program would meet his training needs. It was later discovered that he was actually interested in an advanced degree program and was not eligible for graduate school at the Ohio State University. This episode stimulated a certain amount of curiosity concerning the requirements for a trainee in health services administration. This curiosity led us to further investigate and develop an approved program with MCHS.

On July 23, 1969 the University Affiliated Facilities at Ohio State University requested, through a letter, the approval of a health service administration fellowship for a 1-year duration. While we were in the process of negotiating with MCHS on this training experience, the candidate for whom the request had been made elected not to pursue the fellowship. This abruptly ended our negotiation with MCHS for an approved program. However, a quote is worthwhile from MCHS concerning our negotiations. The quote is taken verbatim from an August 18, 1969 letter and is as follows: "Our primary interest was, and is, recruiting trainees who are enrolled in a master's level program in

the field of administration. In our earlier discussions with you, we agreed to consider, as an alternate, a clinical fellowship for an individual who has already achieved the master's degree." Although our first two experiences were not successful ones, this did not hinder us from continuing our negotiations both with MCHS and with appropriate departments within our University.

In order to satisfy our curiosity we continued to work on this matter of developing an approved administration program. During the summer of 1970 we had several negotiating sessions with the Department of Preventive Medicine at Ohio State who, at the time, seemed inclined to work with us in the development of an approved curriculum. A sample curriculum was developed and forwarded to MCHS for approval. In late fall of 1970, MCHS responded with several suggestions for changing the proposed curriculum. It is my recollection when we took these differences to the chairman of the Department of Preventive Medicine, who had not been closely involved with us in the development of this curriculum, he disagreed with the changes that were proposed by MCHS and that effectively squashed further discussions regarding that curriculum program.

Meanwhile, I had a friend in the School of Public Administration at Ohio State University and had contacted him about developing a curriculum. We met several times to discuss the curriculum development and eventually met with the director of the School of Public Administration. After several meetings, a curriculum program evolved that was sufficient to be sent to MCHS. The curriculum consisted of a Master of Arts in Public Administration with 50% of the student's time to be spent in existing didactic courses in Public Administration and Economics and the remaining 50% to be spent in The Nisonger Center or with other appropriate external agencies. This curriculum program was finally approved by all three constituencies: The Nisonger Center, the School of Public Administration, and MCHS.

After all of these years of negotiation and development, we have not yet received an applicant for the health services administration traineeship. We

continue to receive occasional inquiry concerning this program, but, at this time, we do not have the appropriate funds to support a trainee in administration.

GRADUATE PROGRAM FOR THE ADMINISTRATION OF DEVELOPMENTAL DISABILITY PROGRAMS AND OTHER HEALTH FACILITIES: A JOINT PROGRAM OF THE INSTITUTE FOR HEALTH ADMINISTRATION AND RESEARCH AND THE MAILMAN CENTER

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Introduction

The program developed at the University of Miami for the training of administrators of developmental disability projects is a joint program of the Institute for Health Administration and Research, School of Business Administration, and The Mailman Center for Child Development, School of Medicine.

The program is based on a focused Master of Business Administration degree curriculum concentrating on health administration, which provides an excellent format for such education. In the field of administration the MBA program is the degree most closely related to the management, design and administration of organizations. Studies such as those sponsored by the Kellogg Foundation concerning the location of educational programs for the study of health administration have indicated that schools of business administration contain those education components most important to this field of study. We have analyzed the requirements of the Developmental Disability (DD) field and have organized our educational offerings to meet these needs.

Program Rationale

There are many changes occurring in the health industry. These changes have been in the area of financing health care and in new methods of organization for the delivery of health care. We have directed our program towards developing

students who will be able to deal with existing organizational structures and evolving new combinations for the delivery of health care.

Changes in the area of finance have moved from fee for service, out of pocket payments, towards third party payments and funded programs. This change has imposed an external system of accountability on health organizations which did not exist before. In the past, the health organization was primarily an institutionally "closed" system with little reporting requirements to external agencies, or the need to consider the mandates and actions of outside forces. The health organization has now had to consider these complex and often conflicting outside organizational requirements, such as the requirements that public funding and planning agencies may impose.

Our program is designed to appeal to four basic types of students; the first is the student administrator, the person interested in entering health administration as a career. The second is the individual who holds a position in a health organization that requires administrative knowledge and training. The third group are individuals interested in special certification, and the fourth are administrators of high rank, such as hospital administrators of large organizations, deans of medical schools and others in such positions who wish to be continually kept abreast of the latest concepts in administration.

My presentation today will deal primarily with the first group who are the health administration students, and somewhat with the second group, who are in the staff-related positions. I will attempt to explain the program of study as provided by The Mailman Center for Child Development at the School of Medicine, and the Institute for Health Administration and Research, at the University of Miami. Credit requirements and course sequences are explained in an attached addendum.

Basically, there are two kinds of approaches to management. The first is a "line orientation," for which the MBA was designed. The MBA is therefore differentiated from the masters degrees in such areas as accounting, economics,

and finance, that are primarily designed to develop a staff specialist, the finance person, the accountant, the economist, etc. The MBA was developed to bring together these functional areas in an integrated approach. This was precipitated by difficulties experienced in using narrowly educated individuals in managerial roles. Functional area specialization tends to restrict the ability of the individual to understand the total organization. On the other hand, nonfocused degree programs do not provide for the knowledge and understanding of the functional areas, such as management, accounting, finance, economics, marketing, law, and statistics, and at the same time to study management as an integrative activity. These qualities allow the MBA/Health Administration degree to be particularly suited to the need of the health industry in general and for the education of administrators of developmental disability projects.

The MBA/HA program contains a basic core, or common body of knowledge, and in addition it contains advanced material in the functional areas of administration and extensive course work dealing directly with health administration.

Program Features

Because of the heterogeneity of participants, the program has three points of entry. The first is for those students who have no background in administration, but want to enter the field of health administration. These are students who have an undergraduate degree in any field; they may be an MD, they be a lawyer, or they may have a Bachelor of Arts; any type of nonadministrative degree. These students enter in June and move through our common body of knowledge, which has been contained within a summer program that we call "The Graduate Program in Administrative Studies." This is a 10-week program that covers the first year of graduate level education in business and integrates it into a 10-week program. Now this was quite an undertaking, and I will not go into great detail because

we do not have the time here, but basically what it does is reduce overlap and duplication in the courses. It moves quite rapidly during the summer period, and prepares the student to enter into the advanced phase of the MBA/HA degree in August. August is the second entry point and it would be the normal entry point for a person with administrative background. So you see, here we have two types of students entering in August and moving into second year level coursework.

As you are aware, there are many types of concentration within the field of health administration, and students may or may not have decided on their area of interest prior to entering a health administration program. A particular student may have determined the field of interest such as developmental disability, health planning, or hospital administration. For this kind of student we tailor the program to have the appropriate content to meet those needs. Another kind of student may say, "I want to go into a career in health administration, but I want mobility, and I am not quite sure what part of health administration would provide this to me." This student may take some time to decide, for example, if he or she is interested in employment in a University Affiliated Facility (UAF) or any of the associated job opportunities within this field. Obviously there are many appropriate combinations of courses that offer specialization within the health field, but at the same time flexibility to adapt to various types of administrative health situations. This is an important advantage of the program, in that it allows for wide implementation of administrative concepts to the health field and therefore allows potential for vertical and lateral mobility.

An important concept is the role of the preceptor and the residency within the program I am describing to you today. We have expanded the traditional idea of the preceptor and have identified three types of preceptor functions, all developed within a process-oriented approach. The first preceptor process objective is one of integration. The integrator is normally a person with a senior faculty appointment, and it is that person's responsibility to integrate

all of the courses in the program to focus upon the students' interest. For example, in every course some kind of project or paper is required; in a finance course the student has the option to write on any issue he likes. It is one of the functions of the integrator to work with that student and focus on the health field or the portion of it that the student is interested in. Therefore, when the student finishes the core of the courses and general requirements, that student has a focus of a series of class projects that can be used to substantiate the student's knowledge and understanding of the health field.

The second area is in the more traditional area of preceptorships. This takes two forms that are somewhat different from one another. The first form is in the actual experience field. For example, the administrator of the UAF, in this case The Mailman Center for Child Development, serves as a preceptor for the student. These activities provide a bridge between the situations in the classroom, allowing ideas to be tested against real world situations. The UAF preceptor therefore has the responsibility of evaluating the students' recommendations in a particular area in terms of whether or not they are appropriate in real life settings.

The other portion of the preceptorship is the function of the individual professor in the individual course. For example, taking the finance situation again, you have the testing of the idea that was developed in the finance course against the administrative requirements of the field environment and in terms of the methodology and the application of the financial techniques by the professor of the course. This combination, or team of preceptor functions, provides a more objective point of view, combining advanced concepts taught in the classroom with the pragmatic requirements of the work place. The academician's responsibility is to provide concepts and practical applications; the administrator's is to provide an environment for specific implementation. This is an interesting kind of interaction that keeps everybody moving, and also, you can see it has educational ramifications for everyone concerned: the professor in terms of new

applications, the administrator for learning of new approaches, and the student learning about the feasibility of these concepts in the total health environment.

The third area is an administrative experience, which is a term that I believe to be more descriptive than the term "residency." It may take several forms depending on the background and career objectives involved. For example, it might be for the student who has no experience in health care delivery systems, a means by which we can introduce the realities of the health industry. For example, in the university affiliated environment, several questions should be answered: what is done at a UAF, how does it work? The student may understand concepts, but how does it work in real time? The administrative experience can be used to focus on a specific problem area. For example, we have students who are administrators in hospitals, who come back and want further training. It would be nonproductive to send that person on a residency administrative association to learn about the hospital. What we do in this case is to focus on a particular area within the hospital setting. In some cases an administrative experience is not used because it would be redundant; this is particularly true of people who are coming out of a particular area and are going back to the same area.

In addition, we have a variation on the field experience where we hope to encourage as much movement into real world situations as possible to collect data. There are various health organizations in the community where students are allowed to gather data to make classroom analysis meaningful.

So, basically, that is the general approach to the program. If I were to give you some examples here on some of the approaches we take, if I were to characterize the program, I would say it is a "problem-oriented program," in that it uses management and administration as a way of facilitating objectives and overcoming problems. We define problems in a very specific way in the program, that is, a problem is that which is keeping the organization from achieving its objectives, and therefore, the role of the administrator is to define these proble

in terms of being able to reach the objectives, much in the same way as someone who uses a problem-oriented record attempts to move away from the source information, the discipline information, into an operational problem which then can be approached. Administrative approaches can be organized in a similar fashion, however, they must consider not only a treatment, or a higher state of health for the patient, as would be the case of the medical record, but also cope with and consider the institution, the policies at hand, the resources available, and the providers. It is a more complex kind of problem orientation than just the consideration of the consumer's health needs or specific functional areas within the health setting.

It is obvious then, that if an administrator is to be effective in this kind of role, that an administrator must define the problem operationally. Let us try to develop this problem-oriented record concept a little further and ask ourselves, "What must the administrator ask?" We have to say what resources, what organizational structure and what kind of provider mixes are necessary to achieve the objectives that would need to be developed in the UAF for the particular situation at hand. What we have done is a very interesting kind of thing. We have the administrative student interact with the student in the provider discipline sector. The administrative student has the responsibility of coming up with what might be called a problem-oriented administrative requirement and recommendation, which basically says "Here I am interacting with these people, here are their objectives, here is what they have to do, now how as an administrator could I facilitate these things? What would the provider mix look like? What would the resources look like, etc.? What managerial leadership is required in order for that objective to be reached?"

That provides us with a two-fold benefit--the first is that the administrator is placed in a real life situation; the second is that the people in the functional disciplines of health are exposed to an administrator in a team setting. He has nothing to gain, except to try and find some kind of solution, and hopefully this

will encourage further team development. This is all part of a team building approach, because people do not work by themselves, they have to work with teams. This is a means by which we develop this concept in the institution: with the other students, with the staff people, with the administrator, and with the administrative student. Basically, therefore, the administrative student has to constantly make tests for relevance and significance. He has to say, "What particular factor is relevant and significant for the problem at hand and the objectives at hand, that should be reached? What should I not neglect?"

Evaluation of the student's progress is also very important. What are some of the things that we could do to evaluate the student's progress and see if we are achieving the educational objectives? There are basically three ways to do this. You can look at the reliability and effectiveness of the model proposed that the student administrator presents and you could do this by having the providers and the administrators evaluate the student's model in terms of its reliability--basically, will it do what is necessary to do? You can look at the student's proposal in terms of the analytical skills that were necessary to come up with the reasonable recommendation and does the student have or not have these analytical skills, and then you can look at the effectiveness of these recommendations. All this is done with a program orientation toward line management and administration. The approach is primarily directed toward the health administration student integrating overall concepts, understanding what is happening, and understanding the consequences.

In addition to using existing programs within the school of business we have also taken advantage of existing material that has been developed for the medical provider disciplines within The Mailman Center. We have such things as self-instructional modules, interdisciplinary courses, child development, training teams, service clinics, and intervention programs and the educational conference series. I will not go into them in any detail, because of the time constraint, but basically, they are tailored and designed to provide information for students

applying the concepts of health administration to a UAF. It becomes quite apparent very rapidly if there are gaps in the student's background causing difficulties in applying concepts of administration because the student will not be able to move ahead within the field. Basically what we are attempting to do is to allow the student administrator to develop a more complete data base. Some of you may recognize these terms; I have tried to keep them common to the kind of things that are happening within The Mailman Center, so that we have to do as little defining as possible. Rather than define "data base," you will remember in the past the administrators have operated primarily with a defined data base which is not defined in terms of the administrative needs of the patient or the organization, but the minimal kinds of things one needs to know to consider himself an administrator.

The term "data base" is used here because we do not expect everybody to know everything, but the successful administrator must have a data base to call upon. This is the kind of approach we take and we have attempted to utilize all of the resources that exist at the University. We have attempted not to violate any of the academic traditions and understanding and accreditation requirements, and at the same time be as flexible as we can.

Some of the objectives of the program can be outlined briefly. Trying to demonstrate to the individual administrative student that there is a need for the translation of administrative need at every level of the organization, it is not possible just to say, "We want to improve the health of an individual." You have to define it in terms of each level. It is not enough to way, "We want to become more effective;" you have to come up with plans. You have to understand the policies and the role they play in the objectives and the goals of the organization.

One of the major selling points, students tell us who come to the University of Miami for this kind of degree, is that if they need to move out of a specific area of health administration and wish to go to a different kind of health facility,

they will have all the tools to do this, in addition to having an understanding of the sociology and ramifications of the UAF situation.

In order to show how we organize our program the following Addendum is attached describing the Health Administration Program in detail.

ADDENDUM

1976-77

Health Administration Program

Masters of Business Administration

Institute for Health Administration and Research

School of Business Administration

University of Miami

Coral Gables, Florida

MASTER OF BUSINESS ADMINISTRATION

HEALTH ADMINISTRATION CONCENTRATION

The University of Miami recognizes the increasing need for health administrators to understand the conceptual areas of administration and to be able to apply these concepts within the health system. The program, therefore, brings together the concepts of administration and the systems of health including an understanding of the sociology of the profession, thereby providing a forceful vehicle for persons to acquire the administrative knowledge and problem-solving ability required of successful administrators in health situations.

The University of Miami School of Business Administration, through its Institute for Health Administration and Research, offers advanced instruction in business and health administration leading to a Masters of Business Administration degree with a concentration in Health Administration. This Masters program involves a problem-solving approach to health administration in which the student is able to apply the functional areas of business administration such as accounting, economics, finance, management and marketing to health administration situations.

A multidisciplinary approach to health administration is developed through overall integration of the various important disciplines bearing upon effective and efficient health administration considering the health system in its entirety rather than concentration on health institutions alone. The administration of primary, secondary, and tertiary levels of health care are considered as well as the administration of health research and education.

The universal applicability of administrative concepts are emphasized without losing the important perspectives and characteristics of the health system. The combination of the course content of the University of Miami Masters of Business Administration program and a Health Administration focus allows the student of health administration to apply the powerful concepts and techniques

of business administration to the health setting. In this manner, the student develops competencies important for meeting the challenges and opportunities in present and future health settings.

OBJECTIVES OF THE ADMINISTRATIVE CONCENTRATION

Successful health administrators require an understanding not only of the institution that they are involved with, but also of the implications of changes (both on the level of the individual health organization and on the local and national scene) within the health field. Economic, social, and political changes are of consequence. Changes such as the important legislation which has encouraged the development of Health Maintenance Organizations (HMO) and the impact of professional standards review (PSRO), as well as existing government funding and impending national health insurance, require the administrators to have an understanding of the economic, organizational, sociological, and other relevant implications of these changes.

Changing health technology has caused personnel organization and the relations between provider groups to adjust in the directions necessary for the organizational and administrative support of the technology. Organizational and administrative behavior must be understood and studied through an explanation of organizational activities by analysis which utilizes the methodology and findings of the various administrative disciplines. Consideration of the behavior of people and institutions as a tota. system, as well as the contributions of their various functional components allows a more complete understanding of the process of administration.

Institutional, project, and grant management requires the application of financial, accounting, and quantitative control techniques to the health area. Therefore, skills in the decision and information sciences are stimulated and

managerial skills developed through the application of statistical and mathematical models and theories. These skills can then become useful tools in administrative decision-making within the health area.

The encouragement of high standards of managerial excellence is fostered by the development of an environment for the study of ethical conduct in administrative practices which emphasizes the sensitive nature of the relationship between administration and the health professional, provider, consumer, and the institution.

CONTINUING EDUCATION FOR MENTAL HEALTH, MENTAL RETARDATION/DEVELOPMENTAL DISABILITY ADMINISTRATORS[1]

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Introduction

Jerry Elder of the University of Oregon has described some of the work that has taken place in planning for the education of mental retardation/developmental disability administrators. To refresh your memory, two groups were simultaneously considering this topic. Jerry's group has been addressing the topic of the "Education of Health Service Administrators in an Interdisciplinary Model,"[2] such as a University Affiliated Facility (UAF). His exploration of this question has led, naturally, to broader discussions regarding the preparation of mental retardation/developmental disability administrators.

Simultaneously, another group has been working in a similar area. This is a consortium or task force with representatives of the Association of University Programs in Health Administration, the American Psychiatric Association, and the Association of Mental Health Administrators. That task force is chaired by Mr. Jack Malban from the University of Minnesota. It is staffed by the Association of University Programs in Health Administration (AUPHA). The work of this task force follows a more extensive study, sponsored by the Kellogg Foundation, on the broader issues of education of health administrators. The "Malban Task

[1] Material for this paper was supported in part by: (a) Division of Health Services Training, Bureau of Community Health Services Project No. MCT-001012, (b) Division of Manpower and Training Programs, National Institute of Mental Health, Grant No. MH 10473.

Force" is concerned with a subset of health administrators and mental retardation administrators who work in health settings.

Both groups became concerned with the question of continuing education. Each appointed a subcommittee to develop a position paper regarding the topic, and I was appointed to chair both subcommittees. It seemed very likely that we could combine our efforts and possibly prepare a common document of interest to both groups, and that is what happened.

The subcommittee, appointed by Mr. Malban's group, consisted of William E. Byron, Associate Commissioner, Office of Administration and Fiscal Management, New York Department of Mental Hygiene; Gary Lloyd, PhD, Dean, University of Houston, School of Social Work; and myself. The Mental Retardation/Developmental Disabilities Subcommittee consisted of Jerry Elder, whom you know, and William Garove, PhD, Management Training Program Director, Center for Developmental and Learning Disorders, University of Alabama at Birmingham, and myself. Resources provided to Jerry's group via Maternal and Child Health, Bureau of Community Health Services, enabled us to employ a staff person, Dr. Stephen Shortell from the University of Washington. Steve is an Associate Professor in the Department of Health Services. He not only contributed to the group process but helped to weld the conceptualizations with his knowledge of the education of health administrators, and theories of administration as applied to the health field. Through his unique writing skill and integrated thinking, he drafted what I consider to be a very effective document. Most of this paper is based upon the work of Steve Shortell and the subcommittee.

Working Definition of Continuing Education

It was necessary to distinguish continuing education from in-service training and degree-targeted extended university programs. The operational definition used for this document was that continuing education includes any educational activity for administrators of mental health (MH), mental retardation

(MR) or developmental disabilities (DD) services through which systematic learning opportunities are provided. These activities include formal and informal courses, conferences, conventions, symposiums, seminars, institutes, and workshops, to mention a few formats. It is planned learning beyond the basic education of generic administrative and management skills relevant to the delivery of MH, MR/DD services. By planned learning we mean the development of formal plans of learning, content, and materials with stated objectives and evaluation of both the process and outcome of the learning experience. This definition is not meant to suggest that learning cannot occur in many different settings nor to imply that one format is better than another--only to provide an operational definition for further planning and discussion.

The Conceptual Model of Continuing Education

The framework used was the open systems approach. This approach makes it possible to examine the relationship among the inputs into the educational process, the actual use of these inputs in the educational experience, and the outputs produced. This approach has several advantages. It reflects the interdependence of the continuing education activities; it emphasizes the dynamic nature of continuing education; and it permits a variety of approaches to reaching the same goal.

The Curriculum: Organization and Content

The development of the curriculum would be based on a careful assessment of the needs of practicing administrators. This can be determined by a needs assessment. Once these needs have been identified, it is possible to determine the relevant bodies of knowledge potentially applicable to the issues at hand. It is suggested that matrices be developed which list needs or issues on one axis and potentially relevant bodies of knowledge on the other. This matrix approach provides continuing education participants, both faculty and practitioners, with an overview of the types of disciplines and knowledge bases which

can be drawn upon in designing course content to meet specific learning objectives. The emphasis should be on substantiative generic learning which has utility beyond today's problems and upon the application of basic disciplinary knowledge to the MH, MR/DD administrative setting.

The Curriculum: Implementation Strategies and Learning Methodologies

Continuing education programs may be conducted in a variety of different settings and under a variety of sponsorships, including colleges and universities, organizations affiliated with colleges and universities, such as the Western Interstate Commission on Higher Education (WICHE), programs conducted by professional associations, such as the American Psychiatric Association or the Association of Mental Health Administrators, and programs developed by educational organizations such as the UAF. The sponsorship is probably less important than adherence to the two principles: (a) the course content must be focused on the needs of the field, and (b) there must be involvement with ongoing delivery settings. Perhaps even more important than the sponsorship or the setting is the composition of the faculty and the practitioners. The continuing education process depends on what these two groups can learn from each other. University-based faculty involved in continuing education should be of the same quality as that available to full-time students. However, it is wise to include practicing administrators as members of the faculty. This joint offering increases the likelihood that what is learned in the classroom will be applied in practice.

The continuing education program needs to fully capitalize on the experience and insights which are brought to the learning experience by the participating practitioners. This may mean reducing or abandoning the pedagogical techniques which have frequently proven useful with less experienced individuals in shifting toward a greater experimentation with adult-centered, the so-called andragogical, approaches to learning. A learning reinforcement strategy helps to assure that what is learned in the classroom, in fact, finds its way into practice.

Since continuing education holds the potential for significantly upgrading the quality and skills of practicing administrators in the MR/DD field, it is recommended that high priority be given to the development of these programs. They will require funding. Funding will, undoubtedly, come from multiple sources and the primary candidates are: (a) federal funds, (b) foundation funds, (c) state or agency support, (d) tuition paid by individual participant or employer organization, and (e) university support. In most likelihood "startup and demonstration" funds will have to come from federal and foundation grants. If the programs can prove effective, it is likely that more state and agency support will be forthcoming. In any event, there is an urgent need for stable long-term support which will probably require the incorporation of funds for continuing education into state or agency budgets.

Quality Assessment

As continuing education efforts for MR/DD administrators grow, the issue of program accreditation and individual assessment and recognition will assume increased importance. In light of the proliferation of requesting bodies, it is recommended that existing bodies which accredit various professional schools be used. This form of assessment would require the development of relevant criteria in providing the necessary technical assistance to the generic accrediting body.

Individual assessment and recognition should be achieved through the establishment of standards regarding educational backgrounds for those who serve in administrative roles in MR/DD. Priority should be given to granting academic credit for the continuing education courses. Certification in MR/DD administration would be desirable. It is necessary to develop a common set of criteria supplemented by specialized criteria applicable to this field.

In closing, I want to emphasize that I believe continuing education in the field of MR/DD administration can contribute significantly to many facets

of practice: to the faculty that conceptualizes and coordinates the program, and to the knowledge and skills of course participants. That, in turn, should produce better administration, management, planning, and coordination of the elements of the service delivery system. The fact that these courses are relatively isolated reflects that it requires a great deal of planning and effort to mount one that is beneficial to the various interests that must be served. I know of only one model within a UAF--the program being conducted at the University of Alabama. However, I believe it would be desirable for as many as four to six UAFs to become proficient in this area, and that the work of our group will prove useful to any who are considering such a program. Hopefully, the material will be published and be available later this year. In the meantime, I will be happy to send a draft copy to anyone willing to pay the $7.50 xeroxing and mailing costs.

[2] Elder, Jerry O., et al. Education of health service administrators in an interdisciplinary model. University of Oregon, Health Sciences Center Jan., 1975.

NOMINAL GROUP TECHNIQUE

Moderator

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THE EFFECTIVENESS OF NOMINAL, DELPHI, AND INTERACTING GROUP DECISION MAKING PROCESSES[1]

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A pervasive concern of contemporary administrators is to find effective methods for making decisions when a number of people from different backgrounds and perspectives need to be involved in the problem-solving process. This research focuses upon this concern by experimentally comparing three alternative methods for group decision making: interacting, nominal, and delphi processes.

The traditional and most widely used approach for group decision making in organizational committee life is the conventional interacting or discussion group. The typical format followed in interacting group meetings generally begins with the statement of a problem by the group leader. This is followed by an unstructured group discussion for generating information and pooling judgments among participants. The meeting concludes with a majority voting procedure on priorities, or a consensus decision.

The nominal group technique (hereafter NGT) is a group meeting in which a structured format is utilized for decision making among individuals seated around a table.[2] This structured format proceeds as follows: (a) Individual members first silently and independently generate their ideas on a problem or task in writing. (b) This period of silent writing is followed by a recorded round-robin procedure in which each group member (one at a time, in turn, around the table) presents one of his ideas to the group without discussion. The ideas are summarized in a terse phrase and written on a blackboard or sheet of paper on the wall. (c) After all individuals have presented their ideas,

[1] Reprinted by permission from André L. Delbecq and the Academy of Management Journal. The basic concepts presented at the conference by Dr. Delbecq are included in this paper.

there is a discussion of the recorded ideas for the purpose of clarification and evaluation. (d) The meeting concludes with a silent independent voting on priorities by individuals through a rank ordering or rating procedure, depending upon the group's decision rule. The "group decision" is the pooled outcome of individual votes.

Unlike the interacting or NGT processes where close physical proximity of group members is required for decision making, participants in the delphi technique are physically dispersed and do not meet face-to-face for group decision making.[3] The delphi technique provides for the systematic solicitation and collation of judgments on a particular topic through a set of carefully designed sequential questionnaires interspersed with summarized information and feedback of opinions derived from earlier responses (26).

While considerable variance exists in administering the delphi process, the basic approach, and the one used in this research, is as follows: Only two iterations of questionnaires and feedback reports are used. First, a questionnaire designed to obtain information on a topic or problem is distributed by mail to a group of respondents who are anonymous to one another. The respondents independently generate their ideas in answering the questionnaire, which is then returned. The responses are then summarized into a feedback report and sent back to the respondent group along with a second questionnaire that is designed to probe more deeply into the ideas generated by respondents in the first questionnaire. On receiving the feedback report, respondents independently evaluate it and respond to the second set of questions. Typically, respondents are requested to vote independently on priority ideas included in the feedback report and to return their second responses, again by mail. Generally, a final summary and feedback report is then developed and mailed to the respondent group.

The present research is a formal experimental comparison of the effectiveness of interacting, nominal, and delphi processes for decision making.

RECENT RESEARCH ON GROUP PROCESSES

In a previous article in the Journal (29) the authors reviewed the research literature dealing with alternative processes for group decision making and theoretically concluded that structured nominal groups are more effective than conventional interacting group processes for obtaining the ideas of individuals in face-to-face problem solving committees.

With one notable exception, no previous research has experimentally compared NGT and delphi processes. Gustafson et al. (18) tested the comparative effectiveness of independent individuals, interacting, NGT, and delphi processes on a problem of subjective probability estimation. NGT groups were found to be superior to all others in terms of lowest percentage of error and variability of estimations. The variant of the delphi process tested was the worst; interacting groups and individuals working independently emerged second and third best, respectively. A possible explanation for the poor performance of the delphi process may be that invalid experimental manipulations and testing were used. The authors indicate that due to the expensive interrogation and questionnaire format of the delphi technique, a derivative process called Estimate-Feedback-Estimate was used. This derivative process involved groups of four individuals who were asked to independently estimate likelihood ratios, exchange their estimates through written communications, and then re-estimate their likelihood ratios. The Estimate-Feedback-Estimate process permitted social facilitation of people working in the presence of each other. It could be argued that due to the "unnaturalness" of written feedback communications among group members in the presence of one another, the derivative process induced negative social facilitation.

Contrary to the findings of Gustafson and his associates, experiments carried out by Dalkey (5,6) and Campbell (3) found the delphi process more effective than committee discussions. In these experiments the problem required respondents

to estimate the accuracy of a set of facts. The pooled estimates resulting from the delphi technique were found to be more accurate than were the estimates resulting from the committee discussions.

Since this research dealt with relatively objective probability estimation problems, a question arises as to whether the research results would be the same if a more real-life, controversial, and emotionally involving problem were chosen. One may question, too, whether accuracy and variability of estimations are appropriate criteria of the effectiveness of a decision making technique when the nature of the real applied decisions confronting practitioners is subjective, when frequently there is no one correct solution, and when the decision often directly affects the lives and behavior of decision makers. As a result, the affective, emotional, and expressive dimensions of a problem often subordinate the objective, analytical quality of a decision. The practitioner's overriding criterion in the choice of a decision making process may be the perceived satisfaction of participants affected by the decision, at the calculated expense of solution quality. Indeed, since an objective measure of quality may not exist, political acceptability of the decision may become the measure of quality.

EXPERIMENTAL DESIGN

The Experimental Setting and Problem

The present research was conducted in the Division of Student Affairs at a midwestern university. The problem was that of defining the job description of part-time student dormitory counselors who reside in and supervise student living units of university owned or approved housing. A separate survey of students, faculty, administrators, and parents was conducted to validate the premises that this problem was considered (a) to be very difficult, (b) to have no solution that would be equally acceptable to all interest groups involved, and (c) to evoke highly emotional and subjective responses.

Criteria of Effectiveness

The criteria chosen to measure the comparative effectiveness of NGT, delphi, and interacting methods of group decision making were (a) the quantity of unique ideas developed by groups and (b) the perceived satisfaction of groups with the decision making process in which they were involved.

Quantity of Ideas. The greater the quantity of ideas generated through a decision making process, the greater the number of ideas that are considered in making a decision, and the greater the potential for creative decision making (21, 23). The fact that only a few ideas are generated by a problem-solving group does not preclude the possibility that others may exist. However, Maier (22) suggests that "uncreative groups frequently behave as though this were the case."

Since the steps in generating ideas in NGT and delphi procedures are quite similar, it was predicted that the quantity of ideas generated by the two techniques would be about equal. Because participants are encouraged to "hitch-hike" on one another's ideas in NGT, and because of the social facilitation present in a group setting, it was predicted that NGT groups would produce slightly more ideas than comparable delphi groups.

Previous research has found a number of inhibiting influences when interacting groups engage in problem solving. Therefore the authors predicted that NGT and delphi processes would be clearly superior to interacting groups in the quantity of ideas generated.

The quantity of ideas generated was measured by counting the number of unique ideas developed by each NGT, delphi, and interacting group. A panel of four judges reviewed a listing of the raw ideas generated by each group and edited each group's list to eliminate duplications. Discrepancies between judges were discussed among the judges, and group consensus was used to determine

whether the idea under discussion was unique or a duplicate of other ideas in the group's list.

Perceived Group Satisfaction. A second criterion often cited in the literature (e.g., 14, 21) and chosen by practitioners to measure the effectiveness of a decision making method is the satisfaction participants perceive with group process and decision outcomes. Even when highly creative decisions are developed, if the decision makers feel dissatisfied with the process or cannot accept the solution, the decision may fail to be adopted (10). The greater the participants' perceived level of satisfaction with a decision making process and outcome, the greater the probability of solution adoption (1, 4, 17, 27).

Participant satisfaction with the process and outcome of NGT, delphi, and interacting groups was measured by having all participants in the three treatments complete a standardized evaluation form immediately following the completion of a treatment. The group evaluation form included the following five items relating to satisfaction:

1. To what extent did you feel free to participate and contribute your ideas?
2. To what extent did you feel your time was well spent in this meeting/completing the delphi questionnaires?
3. How satisfied are you with the quantity (number) of ideas generated by your group?
4. How satisfied are you with the quality of ideas generated by your group?
5. To what extent do you feel the group meetings/series of delphi questionnaires, is an effective way to deal with the problem?

Each item was scored on a five point scale, and the total for all was computed. Thus, perceived satisfaction is a ubiquitous measure that includes the affective and emotional dimensions of participation, as well as the perceived analytical quality of the group's performance.

In the NGT and interacting processes, the subtle dynamics of social interaction can facilitate social cohesion within a group (resulting in high feelings of satisfaction), or facilitate fractionated groups with frustrated members (13, 23, 25). On the other hand, where social interaction is not present, as in the delphi process, the perceived satisfaction of respondents may be solely a function of the perceived objective quantity and quality of ideas generated, and the amount of time saved in not having to attend a meeting (7).

The authors predicted that NGT groups would perceive higher satisfaction than would delphi groups because of the social facilitation provided by face-to-face interactions in NGT groups. Further, it was predicted that participants in NGT groups would perceive greater satisfaction than would participants in interacting groups because of the higher potential for inhibiting influences in the latter, e.g., conformity pressures, dominance of strong personality types, covert personalizing judgments, and status incongruities (30).

It is difficult, however, to predict the difference in perceived satisfaction between participants in delphi and interacting groups. The delphi process provides neutral social satisfaction in the sense that no opportunity is provided for face-to-face interaction. The interacting process provides ample opportunities for social facilitation at the expense of decreased satisfaction due to social inhibitions. A priori, therefore, it was predicted that there would be no difference in perceived satisfaction between delphi and interacting groups.

In summary, two criteria measuring effectiveness were chosen to experimentally compare the NGT, delphi, and interacting processes in regard to (a) quantity of ideas generated and (b) perceived level of satisfaction.

Because of the nature of the problem investigated in this study, it was believed that a practitioner would require both high quantity of ideas and high satisfaction by participants to call the outcome of a decision making

process effective. Therefore, in constructing a composite measure of effectiveness, equal weights were assigned to the two dependent measures.

Hypotheses

The hypotheses regarding the effects of the three decision making processes on the composite effectiveness measure can be stated as follows:

1. The NGT process will be more effective than the delphi process.
2. The delphi technique will be more effective than the interacting group process.

The corollary hypothesis is:

The NGT process will be more effective than the interacting group process.

Sample Size and Value of Test Statistic

In order to properly utilize classical hypothesis testing methodology and to enable the use of statistical significance as a quality procedure for measuring magnitudes of effects between the mean effectiveness scores of the three processes, the procedures recently developed by Walster and Cleary (32) and operationalized by Walster and Tretter (33) were utilized. Thus, it was possible to determine simultaneously the appropriate sample size and the critical value of the statistic required to test the foregoing hypothesis in analysis of variance. (ANOVA).[4]

This procedure requires that the researcher make two value judgments to determine the appropriate number of observations and the critical value of the variance ratio statistic:

1. Based upon an index of the magnitude of an effect, Δ, what are considered trivial and important differences between the three decision making processes?

2. With what probability does the researcher wish to correctly draw conclusions that there is a trivial or an important effect?

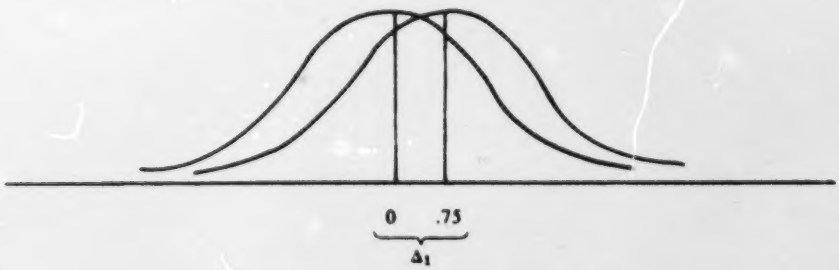
The value judgments made regarding the magnitude of effect between a linear combination of the means of NGT, delphi, and interacting groups were as follows:

1. True values of Δ less than $\Delta_1 = .75\sigma$ will be considered trivial differences between the means of the decision making processes.
2. True values of Δ greater than $\Delta_2 = 1.50\sigma$ will be considered important differences between treatments.

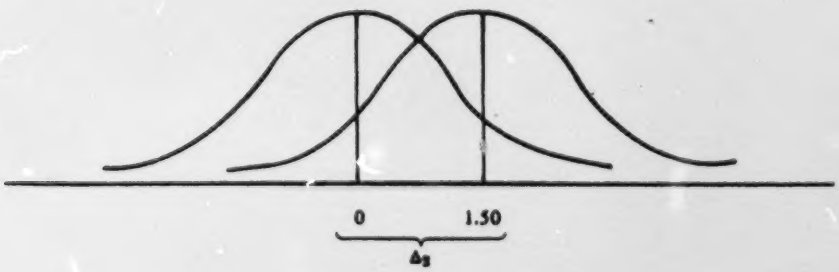
The choices of $\Delta_1 = .75\sigma$ and $\Delta_2 = 1.50$ are illustrated in Figure 1.

FIGURE 1

The Magnitude of an Effect Considered Trivial = $\Delta_1 = .75\sigma$



The Magnitude of an Effect Considered Important = $\Delta_2 = 1.50\sigma$



Complete certainty ($p = 1.00$) in drawing correct conclusions about magnitudes of effect would be the ideal. However, because this would require an infinitely large sample size, levels of assurance less than 1.0 are chosen in reaching alternative conclusions regarding trivial and important results. In this case:

1. The level of probability chosen in deciding that a trivial result ($\Delta < \Delta_1 = .75\sigma$) is indeed trivial is at least .85 ($p_1 = .85$), and
2. The level of probability chosen in deciding that an important result ($\Delta < \Delta_2 = 1.50\sigma$) is indeed important is at least .95 ($p_2 = .95$).

These value judgments are illustrated in Figure 1. It is assumed that the practitioner is reluctant to alter his use of conventional group decision making approaches unless convincing evidence indicates that a less conventional method (e.g., the NGT or delphi technique) is more effective than his conventional approach (i.e., use of the interacting group).

The above judgments of the practitioner can be incorporated into the research design by translating the practitioner's concerns into magnitudes of effect regarding the size of observed differences in effectiveness between NGT, delphi and interacting processes. If it is found that the observed differences between the decision making processes are smaller than $\Delta_1 = .75\sigma$, it is believed that the practitioner will consider this result to be trivial and the effort to alter his customary ways of conducting group meetings to be unwarranted. On the other hand, if observed differences between the decision making techniques are larger than $\Delta_2 = 1.50\sigma$, the practitioner will probably consider this difference important enough for him to alter his decision making process. Finally, should observed differences be greater than $\Delta_1 = .75\sigma$, but smaller than $\Delta_2 = 1.50\sigma$, i.e., $\Delta_1 = .75\sigma < \Delta < \Delta_2 = 1.50\sigma$, the zone of indifference, then it is assumed that the practitioner will suspend judgment in favor of additional data.

On the basis of the value judgments made with regard to magnitudes of effect ($\Delta_1 = .75; \Delta_2 = 1.50$) and probabilities of exercising control over drawing correct conclusions about observed results ($p_1 = .85; p_2 = .95$), a "Samfix" computer program developed by Walster and Tretter (33) provides the appropriate number of 20 observations of each decision making process and the critical values of the variance ratio statistic. The F test must be larger than 6.299 to lead to the decision $\Delta < \Delta_2$. Finally, if the F test is greater than 6.280 and smaller than 6.299, judgment is suspended.

Selection and Composition of Groups

Numerous researchers have examined the leadership between group size and heterogeneity of opinions, difficulty in reaching consensus, and patterns of interaction. They have found that as size increases above some limit (perhaps seven), restraints against participation also increase and the most active participant becomes increasingly differentiated (e.g., 2, 8, 16, 19, 20). Yet in most studies comparing alternative decision making processes, the size of groups ranged from two to four members. Since the size of decision making groups and committees encountered in organizational life is considerably larger, one may question whether the research results on two to four members can have a general application. In this research, the size and composition of a group was chosen to be seven participants from heterogeneous backgrounds (e.g., student residents, student housing administrators, faculty, academic administrators).

A stratified random sampling procedure was followed in assigning 420 individuals to 60 heterogeneous groups--20 NGT, 20 delphi, and 20 interacting groups. For each of the NGT and interacting processes, 20 group meetings were conducted with groups of seven persons. In the delphi process the questionnaire responses were collated into the 20 preassigned respondent groups of seven persons, and 20 independent feedback reports were developed. At all times the unit of analysis in each treatment was a group of size seven.

Random Selection of Leaders

The leaders for the NGT and interacting groups were either graduate students or professional planners. The selection of leaders was based upon previous observations in conducting group meetings. The leaders were all about equally qualified in group decision making. From this selected group, leaders were randomly assigned to one of the two processes and then trained to conduct either NGT or interacting group meetings. The leaders conducted meetings only within their assigned treatments.

Experimental Procedures

The delphi process was the only treatment in which subjects did not work in groups but worked independently by responding to two mailed questionnaires. The first questionnaire requested participants to "list the job activities that should be included in a job description of a House Fellow," and to return their responses in a preaddressed mail envelope. Questionnaires were coded and non-respondents received reminder letters and follow-up telephone calls to insure a high return rate. Questionnaire responses were then collated in terms of the preassigned groups and summarized into 20 independent group feedback reports. On the basis of the feedback reports that included the pooled ideas of other group members, respondents were requested in the second questionnaire to "choose the five most important job activities that should be included in a House Fellow job description." A final feedback report was then constructed for each group. It was mailed back to the respondent groups along with an evaluation form that respondents were asked to complete and again return in a preaddressed mail envelope. Of the 140 respondents who initially agreed to participate in the delphi process, 20 individuals or 14 percent withdrew during the process. This was determined in last-resort follow-up telephone calls to nonrespondents. However, a dropout rate of about equal size occurred among individuals who agreed to participate in NGT and interacting group meetings.

The NGT and interacting groups followed the same respective formats described in the introduction of this paper. Again, as in the delphi process, the same task was assigned to each group. To assure consistency in leadership behavior and in the specific steps followed by groups within each process, NGT and interacting leaders participated in separate briefing sessions prior to each meeting and followed a detailed written format in their meetings. Immediately after the conclusion of each meeting the leader requested participants to complete the evaluation forms. After the NGT and interacting leaders collected the evaluation forms and dismissed their groups, they completed a postmeeting data sheet that included (a) a question to determine if the meeting deviated from the prescribed leader format and (b) a question regarding the leaders' process evaluations of the meetings they had just conducted. Follow-up interviews were held with leaders if the information was not clearly understood by the researchers. Based upon an analysis of this data, the researchers were satisfied that there was consistent performance among the leaders.

Experimental Controls

All decision making processes were conducted independently. To avoid contamination between treatments, NGT leaders were kept separate from interacting leaders at all times. While the leaders knew two types of decision making procedures were being used, no mention was made to leaders of the positive and negative expectations of either process. In addition, group meetings in each treatment were kept physically separated. To avoid grapevine communication problems, all meetings within a particular geographical housing area were conducted simultaneously. All NGT and interacting group meetings were completed in four consecutive evenings.

RESEARCH RESULTS

Table 1 summarized the results of a univariate F test to detect overall differences in effectiveness between NGT, delphi and interacting group processes. The variance ratio statistic (19.1) is far greater than the critical value of the statistic (6.299). Therefore, with at least a 95 percent probability of being correct, it is concluded that there is an important difference (i.e., where $\Delta < \Delta_2 = 1.50$) in effectiveness between the three decision making processes.[5] Since large departures were detected between the treatment means in accordance with Scheffe (24), post-hoc comparisons were made and these also are summarized in Table 1. The differences between the effectiveness of the three decision making processes are as follows: While the difference between NGT and delphi groups is in the predicted direction, it cannot be concluded that it is an important difference. Unlike the overall test, however, it cannot be concluded that this difference is small; only that it is not too large. To demonstrate that is is small, a new experiment is required in which this difference is investigated a priori.

However, there are large and important differences between the effectiveness of NGT and interacting groups, and between delphi and interacting groups, as predicted. It can be concluded that the second and third comparisons account for most of the overall significance of the F test.

The hypothesis of large differences in effectiveness between NGT, delphi, and interacting group means is partially supported. On all pair-wise comparisons, differences in effectiveness between the three decision making processes are in the predicted direction. The degree of differences in effectiveness between NGT and interacting groups and between delpi and interacting groups is important and large. These differences are so convincingly large that if one agrees with the value judgments used regarding what is large and important ($\Delta < \Delta_2 = 1.50$),

the practitioner should alter his conventional pattern of using the interacting group meeting in favor of either NGT or delphi techniques on applied problems of the type used in this study. However, it cannot be concluded with the same degree of confidence that the practitioner should favor the NGT process over the delphi technique since the difference in effectiveness between NGT and delphi is not large.

In order to investigate these differences more deeply, post hoc multiple comparisons were made on the component variables contained within the composite effectiveness source. Ninety-nine percent simultaneous confidence intervals were chosen to test differences between the three decision making processes on the quantity of ideas generated and perceived group satisfaction. They are summarized in Table 1. The differences between NGT, delphi, and interacting groups are as follows:

1. As predicted, there is no significant difference in the quantity of ideas generated by NGT and delphi groups. On the average, however, NGT groups generated 12 percent more unique ideas than did equivalent delphi groups.
2. As predicted, significantly more ideas were developed by delphi than by interacting groups ($p < .01$). The delphi technique generated 1.6 times more ideas than did the interacting group process.
3. As predicted, the greatest difference in terms of the quantity of ideas is between NGT and interacting groups ($p < .01$). On the average, NGT groups generated nearly twice as many ideas as did interacting groups.
4. As predicted, NGT groups expressed significantly greater satisfaction with their process than did delphi respondents ($p < .01$).
5. The greatest difference in perceived group satisfaction between the three decision making processes is between NGT and interacting groups, with the former higher than the latter ($p < .01$).

6. As predicted, there is no significant difference in satisfaction between delphi and interacting groups. The satisfaction scores are practically identical for these two decision making techniques.

TABLE 1

Statistical Findings

Overall UANOVA F-Test on Effectiveness of Decision-Making Processes

Source	*SS*	*d.f.*	*MS*	*F*
Between groups	3,054.0	2	1,527.0	19.1
Within groups	4,570.9	57	80.2	
Totals	7,624.9	59		

Basic Statistics

Measure	*NGT Mean*	*Delphi Mean*	*Interacting Mean*	*Standard Error*	*99% Confidence Interval*
Effectiveness	54.1	37.9	26.9	2.8	$10.08 \pm \Psi$
Quantity of ideas	33.0	29.0	18.0	18.5	$4.77 \pm \Psi$
Perceived satisfaction	21.1	19.1	18.8	7.6	$1.97 \pm \Psi$

Post Hoc Comparisons on Composite Effectiveness Measure

Comparison	*Contrast*	*Value of* Ψ	*Decision*
NGT—Delphi	$T_1 = 1 \ -1 \ 0$	$54.1 - 47.9 = 6.2$	Not significant
NGT—Interacting	$T_2 = 1 \ 0 \ -1$	$54.1 - 36.9 = 17.2$	Significant
Delphi—Interacting	$T_3 = 0 \ 1 \ -1$	$47.9 - 36.9 = 11.0$	Significant

Post Hoc Comparison on Quantity of Ideas Generated

Comparison	*Contrast*	*Value of* Ψ	*Decision*
NGT—Delphi	$T_1 = 1 \ -1 \ 0$	$33 - 29 = 4$	Not significant
NGT—Interacting	$T_2 = 1 \ 0 \ -1$	$33 - 18 = 15$	Significant
Delphi—Interacting	$T_3 = 0 \ 1 \ -1$	$29 - 18 = 11$	Significant

Post Hoc Comparisons on Perceived Group Satisfaction

Comparison	*Contrast*	*Value of* Ψ	*Decision*
NGT—Delphi	$T_1 = 1 \ -1 \ 0$	$21.1 - 19.1 = 2.0$	Significant
NGT—Interacting	$T_2 = 1 \ 0 \ -1$	$21.1 - 18.8 = 2.3$	Significant
Delphi—Interacting	$T_3 = 0 \ 1 \ -1$	$19.1 - 18.8 = 0.3$	Not significant

DISCUSSION

The research results clearly show that important differences exist between NGT, delphi, and interacting processes on an applied problem. However, these quantitative findings do not explain why such differences exist. In order to interpret the results qualitatively and to investigate more deeply the distinguishing process characteristics of NGT, delphi, and interacting groups, open-

ended evaluations by participants and leaders were elicted immediately after the conclusion of each decision process.

Included in the evaluation form were two open-ended questions:

1. In general, what did you like the most about the meeting/delphi you just participated in?
2. In general, what did you dislike the most about the meeting/delphi you just participated in?

For each question, the open-ended responses within each of the 60 groups were content analyzed (15). The 20 group responses in each of the three decision making processes were then tallied and combined under major headings.

A thorough analysis of participants' and leaders' evaluations is available in Van de Ven (28) and provides the bases for profiling the comparative merits of the three decision making techniques. A summary of the qualitative differences that were found between NGT, delphi, and interacting processes is given in Table 2. The qualitative results support present and previous research which finds there are a number of inhabiting influences that reduce the performance of interacting groups in decision making:

1. Because interacting group meetings are unstructured, high variability in member and leader behavior is observed from group to group.
2. Too much effort is directed toward maintaining social-emotional relationships among group members, and too little attention is given to performance of task-instrumental roles.
3. The absence of an opportunity to think through ideas independently results in a tendency for ideas to be expressed as generalizations that are low in quality.
4. Search behavior is reactive and characterized by short periods of focus on the problem, tendencies for task avoidance, tangential discussions, and high efforts in establishing social relationships and generating social knowledge.

TABLE 2

Comparison of Qualitative Differences Between Three Decision Processes Based upon Evaluations of Leaders and Group Participants

Dimension	*Interacting Groups*	*Delbecq-Van de Ven Nominal Groups*	*Dalkey Delphi Technique*
Overall methodology	Unstructured face-to-face group meeting High flexibility High variability in behavior of groups	Structured face-to-face group meeting Low flexibility Low variability in behavior of groups	Structured series of questionnaires & feedback reports Low variability respondent behavior
Role orientation of groups	Socio-emotional Group maintenance focus	Balanced focus on social maintenance and task role	Task-instrumental focus
Relative quantity of ideas	Low; focused "rut" effect	Higher; independent writing & hitchhiking round-robin	High; isolated writing of ideas
Search behavior	Reactive search Short problem focus Task-avoidance tendency New social knowledge	Proactive search Extended problem focus High task centeredness New social & task knowledge	Proactive search Controlled problem focus High task centeredness New task knowledge
Normative behavior	Conformity pressures inherent in face-to-face discussions	Tolerance for nonconformity through independent search and choice activity	Freedom not to conform through isolated anonymity
Equality of participation	Member dominance in search, evaluation, & choice phases	Member equality in search & choice phases	Respondent equality in pooling of independent judgments
Method of problem solving	Person-centered Smoothing over and withdrawal	Problem-centered Confrontation and problem solving	Problem-centered Majority rule of pooled independent judgments
Closure decision process	High lack of closure Low felt accomplishment	Lower lack of closure High felt accomplishment	Low lack of closure Medium felt accomplishment
Resources utilized	Low administrative time, and cost High participants time and cost	Medium administrative time, cost, preparation High participant time and cost	High administrative
Time to obtain group ideas	1½ hours	1½ hours	5 calendar months

5. There is a tendency for group norms to emphasize conforming behavior among members and for discussions to dwell on areas of agreement.
6. There is a tendency to dominance in search, evaluation, and choice of group product by higher status, more expressive, or stronger personality types.
7. There is a tendency for meetings to conclude with high perceived lack of closure, low felt accomplishment, and low interest in future phases of problem solving.

The Delbecq-Van de Ven nominal process, on the other hand, is a structured group meeting that includes a number of facilitative characteristics which act to increase decision making performance of groups. They are:

1. There is consistency in decision making, as low variability in member and leader behavior is observed from group to group.
2. A balanced concern for socio-emotional group maintenance roles and performance of task-instrumental roles offers both social reinforcement and task accomplishment rewards to group members.
3. The opportunity for individuals to think through and write down their ideas results in a tendency for ideas to be problem centered, specific, and of high quality.
4. The structured group norm emphasizes tolerance for nonconforming, incompatible, or conflicting ideas through independent individual expression of ideas without interruptions during the search and choice periods of decision making.
5. The structured process forces equality of participation among members in generating information on the problem. While dominant members are more expressive during the discussion period, their ideas are simply included in the sample of ideas already listed

on the chart on the wall. Finally, the silent independent voting on priorities forces equality of participation in choice of the group product.

6. The NGT group meetings tend to conclude with a perceived sense of closure, accomplishment, and interest in future phases of problem solving

There are both facilitative and inhibitive characteristics in the delphi process which act to increase or decrease decision making performance. The major characteristics of the delphi process that inhibit decision making performance are:

1. There is no opportunity for social-emotional rewards in problem solving. Respondents focus all efforts on task-instrumental role activity, derive little social reinforcement from others, and express a feeling of detachment from the problem solving effort.
2. The absence of verbal clarification or comment on the feedback report of ideas generated by anonymous group respondents creates communication and interpretation difficulties among respondents.
3. Conflicting or incompatible ideas on the feedback report are resolved by simply pooling and adding the votes of group respondents. No opportunity exists for face-to-face problem solving. Thus, while this majority rule procedure identifies group priorities, conflicts are not resolved.

The facilitative characteristics of the delphi process which act to increase decision making performance are:

1. The isolated generation of ideas in writing results in a high quantity of ideas.
2. The process of writing responses to the questions forces respondents to think through the complexity of the problem and to submit specific, high quality ideas.

3. Search behavior is proactive since respondents cannot react to the ideas of others. The period of "problem mindedness" is controlled and separated from the period of "solution mindedness" by the use of different questionnaires for each phase of problem solving.
4. The anonymity and isolation of respondents facilitate a freedom from conformity pressures.
5. The delphi process tends to conclude with a moderate perceived sense of closure and accomplishment, but with detachment.

CONCLUSION

This research made a formal experimental comparison of the effectiveness of alternative group decision making processes on an applied problem that was characterized as very difficult, had no solution that would be equally acceptable to different interest groups, and aroused highly emotional and subjective reactions. Effectiveness was defined as the quantity of unique ideas generated by a group and the perceived level of satisfaction group participants experienced with the decision process. Twenty NGT, 20 delphi, and 20 interacting groups, each composed of seven heterogeneous members, were experimentally compared.

The statistical procedures being developed by Walster, Cleary, and Tretter were incorporated into this experimental design. These procedures provide the researcher with a qualitative method for utilizing classical hypothesis testing methodology in making decisions of interest and relevance to the user of this research--the practitioner.

Utilizing these procedures, it can be said that if one agrees with the stated value judgments regarding what is large and important, the degree of differences in effectiveness between NGT and interacting processes, and between delphi and interacting groups, is important and large. These differences are so convincingly large that the practitioner should change his conventional pattern

of using the interacting group meeting process in favor of either NGT or delphi techniques on applied problems of the kind used in this study.

This research suggests that when confronted with a fact finding problem that requires the pooled judgment of a group of people, the practitioner can utilize two alternative procedures: (a) the Delbecq-Van de Ven nominal group technique for situations where people are easily brought together physically, and for problems requiring immediate data, and (b) the Dalkey delphi technique for situations where the cost and inconvenience of bringing people together face-to-face is very high, and for problems that do not require immediate solution. Both the nominal group technique and the delphi method are more effective than the conventional discussion group process.

FOOTNOTES

[2] NGT was developed by André L. Delbecq and Andrew H. Van de Ven in 1968 from social-psychological studies of decision conferences, studies of industrial engineering problems of program design in the NASA aerospace field, and social work studies of citizen participation in program planning. Since that time, NGT has gained extensive use and recognition in health, social service, education, industry, and public administration organizations (9, 10, 11, 12, 28, 29, 30, 31).

[3] The delphi process was developed by Norman Dalkey and his associates at the RAND Corporation. It has gained considerable recognition and use in public administration agencies for the purpose of achieving a number of possible objectives:

To determine or develop a range of possible alternatives.

To explore or expose underlying assumptions or information leading to different judgments.

To seek out information which may generate a consensus on the part of the respondent group.

To correlate informed judgments on a topic spanning a wide range of disciplines.

Varied applications of the delphi technique have been demonstrated (3, 5, 6, 7, 26).

[4] Space does not permit a detailed discussion of the useful applied statistical tools developed by Walster, Cleary, and Tretter to maintain control over power, and thereby allow statistical significance to be a qualitative decision rule to determine questions of interest in fixed effects ANOVA. For a complete discussion, see the book by Van de Ven (28).

[5] It should be noted that the probability of incorrectly deciding that $\Delta < 1.50$ given that $\Delta < .75$ is less than .15. In the terminology of classical hypothesis testing methodology, the probability of rejecting $H_0: \Delta = 0$ given that the H_0 is true is equal to .003 (i.e., $a = .003$).

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SUMMARY OF LEADER GUIDELINES FOR CONDUCT OF THE NOMINAL GROUP TECHNIQUE

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Appropriate role definition is important to establish effective group participation. The Nominal Group leader's welcoming statement should therefore include:

1. A cordial and warm welcome.
2. A sense of importance concerning the group's task.
3. Clarification of the importance of each member's contribution.
4. An indication of the use or purpose of the meeting's output.

Step 1: Silent Generation of Ideas in Writing

Leaders should follow four key guidelines and manifest appropriate behavior:

1. Resist nonprocess clarifications.
2. Have the question in writing.
3. Model good group behavior by writing in silence.
4. Sanction individuals who disrupt the silent independent activity.

Step 2: Round-Robin Recording of Ideas

Round-robin recording means going around the table and asking for one idea from one member at a time from the list he or she generated independently in Step 1. Leader requirements for this step include:

1. Clear verbal statement of the step:
   a) The objective is to map the group's thinking.
   b) Ideas should be presented in brief words or phrases.
   c) Ideas will be taken serially.

d) Duplicate items should be omitted.

e) Variations on a theme are desirable.

2. Effective mechanical recording.

3. Direct sanction of inappropriate group behavior.

Step 3: Serial Discussion for Clarification

The main responsibility of the leader relative to serial discussion are:

1. To verbally define the role of the step as clarification.

2. To pace the group in order to avoid undue argumentation or neglect of some items at the expense of others.

Step 4: Preliminary Vote on Item Importance

The simplest and most often used voting procedure in Nominal Group Technique (NGT) is a rank-ordering which entails the following leadership steps:

1. Ask the group to select from the entire list of ideas on the flip chart, a specific number of "priority" or most important items:

   a) Have group members place each priority item on a separate 3 X 5 card.

   b) After members have their set of priority cards, have them rank-order the cards, one at a time.

2. Collect the cards, shuffle them, and record the vote on a flip chart in front of the group.

Step 5: Discussion of the Preliminary Vote

The role of the leader in Step 5 is to:

1. Define the task of this discussion as clarification, not social pressure.

2. Ensure that the discussion is brief, so as not to distort perceptions of items not discussed.

Step 6: Final Vote

This final step in the NGT combines individual judgments into a group decision. It is possible to follow the same voting procedure used in Step 4, the Preliminary Vote. It is also possible to use more refined voting techniques, such as rating. Voting forms may be used to obtain mathematical ratings. If one desires an understanding of the magnitude of differences between priorities, a rating of priorities is preferable. In general, a simple ranking of priorities, as generated in Step 4, is sufficient.

Specific instructions and sample forms are explicated in Chapter 3, "Guidelines for Conducting NGT Meetings," of Group Techniques for Program Planning: A Guide to Nominal Group and Delphi Processes, by André L. Delbecq, Andrew H. Van de Ven, and David H. Gustafson, published by Scott Foresman and Company.

APPLICATIONS OF THE NOMINAL GROUP TECHNIQUE (NGT) FOR ADMINISTRATORS

Example Problems

The administrative assistant of a Midwestern University Affiliated Facility (UAF) will act as preceptor for the first two of a proposed six administrative interns for the next six months. While he/she hopes that the elements of this experience will satisfy their individual objectives for the internship, he also knows that the success of this collaboration with their university departments and advisors will relieve growing resistance to the UAF's "intrusion" in departmental operations. At the same time a smooth "trial," internal to the UAF, would facilitate the acceptance and incorporation of this training component with existing discipline-related intern programs.

A regional school district has contracted with the UAF diagnostic clinic to provide educational (diagnostic) prescriptions for their severely multiply-impaired

population. A coalition of advocate groups opposes clinical prescriptions apart from parent involvement. The district asks for an effective model high in participant satisfaction.

The UAF research division recently named new disciplinary chiefs. Interdisciplinary communication has been declining. The division administrator is concerned about further decay during the transition period. He/she plans a division meeting to generate solutions for this common problem and to introduce the new chiefs.

As illustrated in these vignettes, UAF administrators inherit a broad range of goals and complex organizational relationships. Their posture may be simultaneously superior and subordinate vis a vis UAF and university policies. Funding and staff are multi-level yet often demand equal recognition and participation[1]. As a member of this complex organization, they may have to assume both leadership and participatory roles in decision making[2]. The UAF, as an interdisciplinary organization, is necessarily dependent upon effective, interactive group decision making within training, service and research units.

In applied problems, the NGT has proven successful with respect to idea generation, equal participation and participant satisfaction among interacting groups[3]. It can be a valuable part of an administrator's repertoire of management practices and could be applied to each of the above situations.

Its effectiveness compared to other interacting group processes is fully described in "The Effectiveness of Nominal, Delphi, and Interacting Group Decision Making Process," Academy of Management Journal reprint, Vol. 17, No. 4 (1974). Complete procedural guidelines are in Group Techniques for Program Planning: A Guide to Nominal Group and Delphi Processes, by Delbecq, Van de Ven and Gustafson (Scott Foresman and Company, 1975).

FOOTNOTES

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[2] Clouse, Wilburn. "The UAF Organization in the University Structure: Conflicts, Promises and Problems," in Management Improvement Workshop, New Orleans, November 12-14, 1973, p. 18.

[3] Academy of Management Journal, Vol. 17, No. 4 (1974), p. 605.

NOMINAL GROUP TECHNIQUE (NGT) APPLIED TO

UAF TRAINING PROGRAMS

Conference Participants

The NGT procedure was applied in a group setting to all three training models which were previously discussed. Conference participants were divided into groups based on interest and were requested to apply the NGT to the following questions:

1. What are the critical steps necessary to establish Model 1 - Administration Training in the UAF Core Curriculum?
2. What are the critical steps necessary to establish Model 2 - Preceptor/ Intern Program.
3. What are the critical steps necessary to establish Model 3 - Administration Degree Programs: UAF and University Relationships?

The application of NGT to the three questions resulted in the following plan for each model.

Model 1 - Administration Training in the UAF Core Curriculum

The group used the NGT procedure to produce the following 19 critical steps:

1. To determine faculty--who is going to teach.
2. Realization of problem or subject matter to be taught--scope, managerial, administrative, fiscal.
3. Written commitment by various departments to be involved.
4. Stimulation of discipline interest perceived needs, for training in administration.
5. Establish purpose of developing core curriculum--how it relates to DD legislation, state plan, specific UAF and university(ies)
6. Determine teaching mode, methods, type instruction, number faculty participating didactic vs. problem solving, etc.

7. Coordination of ideas, personnel, resources to conduct plan.
8. Needs assessment--job market.
9. Establish parity among disciplines with regard to faculty appointments.
10. Obtain input from departments.
11. Determine relationship of core curriculum to other programs--degree or otherwise.
12. Approval, review and reappraisal of plan--departments, schools, agencies.
13. Seek funding for trainees.
14. Recruitment of students in administration for rotating through the UAF.
15. Written handbook of core curriculum--application, review, content, etc.
16. Implement plan.
17. Assessment of effectiveness.
18. Revise as appropriate and necessary.
19. Relate to continuing education of faculty and graduates--retraining, certification.

The rank order method was used to rank the eight items with highest priority. They are as follows:

1. 5-Establish purpose of developing core curriculum--how it relates to DD legislation, state plan, specific UAF and university(ies).
2. 6-Determine teaching mode, methods, type instruction, number faculty participating didactic vs. problem solving, etc.
3. 10-Obtain input from departments.
4. 12-Approval, review and reappraisal of plan--departments, schools, agencies.
5. 16-Implement plan.

6a. 7-Coordination of ideas, personnel, resources to conduct plan.

6b. 17-Assessment of effectiveness.

7. 8-Needs assessment--job market.

Model 2 - Preceptor/Intern Program

The group utilized the NGT procedure to produce the following 27 critical steps:

1. Establish liaison with the academic program.
2. Get UAF administrative approval.
3. Determine target areas.
4. Get the commitment of UAF administration.
5. Determine target areas for curriculum development.
6. Establish criteria for selection of trainees.
7. Get UAF staff commitment.
8. Get insurance that time will be available to implement the program.
9. Arrange for funding.
10. Select appropriate academic department.
11. Establish prerequisite skills for trainees.
12. Recruit trainees by promoting the UAF within the academic program.
13. Set up training program.
14. Make appropriate space assignments.
15. Design objectives for trainees.
16. Design an inservice training program for preceptors.
17. Establish joint appointments if necessary.
18. Define evaluation criteria.
19. Demonstrate value of program to academic community.
20. Make time available for preceptor/intern supervision relationship.
21. Invite consultants from academic departments.
22. Secure cooperating university's approval.
23. Negotiate preceptor status and rank with academic department.
24. Establish a set of criteria for choosing preceptors.
25. Arrange training schedules and training experiences.

26. Have curriculum approved by appropriate approval bodies.

27. Field test the training program.

These 27 steps are the result of utilizing the first phase of the Nominal Group Technique. The second phase involved clarifying to the group's satisfaction the steps produced in the first phase. As a result of this clarification, steps 3, 11, 13 and 20 were eliminated because they were redundant with other steps. The remaining steps were then ranked by importance by the group and the following is a result of this ranking.

The eight steps that received the highest score by summing the rank designations for each step are the following:

9. Arrange for funding.

2. Get UAF administrative approval.

18. Define evaluation criteria.

8. Insure the availability of time.

6. Establish criteria for selection of trainees.

5. Determine target areas for curriculum development.

1. Establish liaison with academic program.

15. Design objectives for trainees.

The eight steps that received the highest frequency of votes are the following:

9. Arrange for funding.

18. Define evaluation criteria.

6. Establish criteria for selection of trainees.

2. Get UAF administrative approval.

8. Insure the availability of time.

1. Establish liaison with academic program.

5. Determine target areas for curriculum development.

15. Design objectives for trainees.

Both methods of scoring resulted in the inclusion of the same eight steps. The arrangement of the steps were slightly different, but it is fairly conclusive that there was concensus within the group as to which were the most important steps.

Considering the eight most important steps and including those steps that received at least one vote, a summarization by type of step was made. The following five types of activities are listed according to their relevant importance as determined by the group voting.

1. Development of the training process.
2. Approval and commitment of the UAF.
3. Approval and commitment of the academic community.
4. Funding.
5. Selection and training of preceptors.

It was the final conclusion of the group that all of the steps that survived the clarification phase would be important in establishing a preceptor/internship program in a UAF. The voting technique was important for establishing priorities but not necessarily for eliminating steps.

Model 3 - Administration Degree Programs: UAF and University Relationships

The group used the NGT procedure to produce the following 26 critical steps:

1. Faculty appointment of UAF administrator to graduate program.
2. Do a feasibility survey to determine if it could work on that campus.
3. Establish the credibility of the UAF in academic area.
4. Develop draft of a curriculum proposal.
5. Identify qualified instructors.
6. Finding graduate program amenable to the idea of DD-MR tract and its program.
7. Agree upon a degree level.
8. Decide that the appropriate persons have the desire, time and talent to participate.

9. Define a student/trainee population.
10. Identify a funding source for the program.
11. Convince UAF director and staff of the need and usefulness for program.
12. Agree upon a format such as resident/day school, continuing education or extended university.
13. Agree upon relationships desired in order to be acceptable to graduate school.
14. Define an evaluation process.
15. Criteria for admission to program.
16. Document the manpower need for MR/DD graduates of the program.
17. Decide on thrust of the curriculum.
18. Sell program to the funding agency.
19. Generate an interest in the program so students will enter it.
20. Agree on intern and extern possibilities needed and/or available.
21. Project evaluation and review technique.
22. Dealing with problem of tenure for faculty.
23. Agree on the number of credits to be required and whether a thesis will be required in the case of a masters.
24. Obtain a facility for the program.
25. Generate funding for faculty and/or student stipends.
26. Obtain general concurrence within the UAF.

These 26 steps are the result of utilizing the first phase of the Nominal Group Technique. The second phase involved clarifying to the group's satisfaction the steps produced in the first phase.

The eight steps that received the highest score by summing the rank designations for each step are the following:

8. Decide that the appropriate persons have the desire, time and talent to participate.

25. Generate funding for faculty and/or student stipends.
6. Finding graduate program amenable to the idea of DD-MR tract and its program.
11. Convince UAF director and staff of the need and usefulness for program.
17. Decide on thrust of the curriculum.
26. Obtain general concurrence within the UAF.
3. Establish the credibility of the UAF in academic area.
14. Define an evaluation process.

The groups felt that the Nominal Group Technique is an excellent technique in establishing a plan that is widely accepted by groups. Most of the group members felt that they would have occasion to utilize the Nominal Group Technique in their own UAFs.

ADMINISTRATION TRAINING: FUNDING CRITERIA AND FUTURE POSSIBILITIES

Moderator

Jerry Elder
University Affiliated Facility
University of Oregon
Medical School

MATERNAL AND CHILD HEALTH GUIDELINES

Jim Papai
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Health Services Training Branch
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Maternal and Child Health Services Viewpoint

I want to discuss two different aspects of administration training. One is sort of a historic perspective of our agency interest in the subject, and the other, of course, is the funding realities as they may or may not affect what we are concerned with.

To me, probably, the biggest accomplishment of this meeting is the fact that, indeed, it could even be held. Going back several years to the early days of the University Affiliated Facility (UAF) program, we insisted from the beginning that in each and every program we funded there would be an administrator, and from the beginning we insisted that we wanted that person there for two reasons. One was to be in essence a business manager to see that the rather considerable investment of public funds in the program would be adequately managed. Indirectly related to that was the feeling that the program director ought not to be the person who would be responsible for doing that, primarily because he had many other things to do and because he did not have training in that particular area. So, the management aspect is one of the reasons we insisted that the administrator be part of the staff.

The second reason, and one that inevitably raised eyebrows, was our insistence that the administrator ought to be part of the faculty and be a participant in the training program going on within those centers. Nobody really quite believed this. The administrators in particular did not believe it, with perhaps one or two exceptions. Most directors smiled and nodded benignly, because they knew that if they were to get their money they would have to agree to this sort of thing. But they really did not think we meant it, and certainly

they did not mean it because this was not an accepted pattern. But we did mean it and we kept yakking about it and those of you who have been around for awhile have heard us talk about it and insist that it should be happening and so on.

As we began the early efforts that led to this meeting there was still a great deal of reluctance on the part of many to assume this role or to even see it as an appropriate role within the UAF. Without belaboring the issue further, we have arrived at a stage represented by this conference in which I think a very substantial change is evident. The discussions here were really not whether one ought to be involved in this sort of thing at all but really how do we do it, what is feasible, what is the appropriate input, etc. In other words, there is an acceptance of this function and this input into the program, which simply was not evident heretofore.

Again, our agency's view of this. As I said, our primary interest was to see that there was administrative input into the training of everybody who went through a center. Our overall training mission in the UAF program, as with most of our other training programs, is the development of leadership kinds of people for the field of maternal and child health, broadly viewed. And, if indeed they are to be leadership people then, as you have all been discussing for the last couple of days, they will achieve positions which involve administrative aspects, if not being completely identified as administrators. Supervisory kinds of positions, program directors, whatever, in which they need to know some of the principles and their applications, as well as some of the factual content primarily identified with the administrator. Not that they will be administrators, but they will do better in their jobs if they know these. So, this we have felt from the beginning was the primary role, and we still feel that way. The discussions of the last couple of days have gone beyond that, to the formal training of administrators, and that is excellent. That is a secondary interest we have also had. But to stick with the first one, in terms of the realities of budgets, and so on, I do not think that this effort requires much by way of financial

resources to effect a change in the program. Obviously, you are all short of time, but then so are all of the people you work with, with very few exceptions, in the other professions.

Each of them is responsible for carrying the program area in a clinical sense the same as you are for the administrative functions of the programs. I do not wish to belittle in any sense the demands on your time, but I do think that as they do, you also have enough time and it is worth making the time, to have an input into the training of all of the disciplines that come through your programs. So, in that sense, I think a great deal can be done without too much concern about whether additional resources are available or not. I know, from the looks on your faces and from discussions with many of you, you do not really believe me. But I have said it and I will stay with it because I have had the same discussions with the other people you work with in your programs and it is one of those make-do kinds of things.

Administration Training and Funding

Now, to the aspects of training that has to do with administrators, either in the internship area or in the graduate degree program. Here, there begins to be a little bit of split between our agency mission and the broader mission of the UAFs. They are not incompatible but they are not one-to-one. What I mean by that, is that obviously we have a legislative mandate and a program mandate to train people for service in the general field of maternal and child health. Your programs have a broader mandate. This is fine. It just happens you get into some areas that, from our program standpoint, we cannot support. There are right now a couple of the programs, at least, training administrative people who do not relate to what we would see as a maternal and child health area of interest. That is fine but that, in terms of direct support, falls outside of our mission. There is, however, an area of training for administrators which we feel does fall within our interest and our mission and that we

would very much like to see happen. I would not want to see the discussions of the last couple of days confused on the basis of whether or not it is appropriate in terms of Maternal and Child Health (MCH) support. Some will be, and some will not. I think what you are concerned with goes beyond whether or not it is of primary interest to us. If you draw two circles, representing your interests and ours, they overlap in part. We are talking of our mutual interest in the part that overlaps. I think to get into this does require some allocation of resources, which is a problem. I think it is essentially the same whether we are talking about internships in this instance, or we are talking about graduate degree programs.

So, the realities of budgeting. This is terribly complicated, because of two things which have happened. First, the budget itself is an up-and-down thing, as you are all painfully aware. The administration annually and routinely submits a budget calling for a reduction. The Congress, with a little persuasion every now and then, has just as routinely restored or sometimes expanded that budget. It is a very tenuous business at best and you all know what we went through this year and how close it came to disaster. There are a couple of things hanging on the horizon for next year that I suspect you are not as aware of. The first is that again the regular budget message from the President to the Congress calls for a reduction, a substantial reduction, in the maternal and child health research and training. The same as last year, we will see what happens on that. The second, and potentially very major development is the so-called Bloc grant which has been purposed by the President. In this he recommends that 16 major health programs, including the Title V Maternal and Child Health programs, will all be lumped together and simply be given to the States on a prorata basis and the States will have complete authority over what they do with those funds. I have had some side discussions with some of you here about that. Included in the draft bill, which I did have a chance to see last week, is a provision that calls for continuation of the research and

training in maternal and child health. But one needs to know more than the fact that it is included. The way it is written, the States would have to continue to support those projects which are presently funded for at least 3 years. There is hooker number one. Hooker number two is that the rate of support need only be 80% the first year, 50% the second, and 25% the third. That does not mean that the States could not continue to support you, but that is the only mandate they would have. We feel, and most of you that I have talked with and most other people feel, that this bill is not going to pass. I think it behooves us collectively to see that it does not pass. And, if nobody seems disturbed at the prospect of it, if there is not an indication to the members of Congress and somewhat within the administration that this is not meeting with universal favor, it might pass. Aside from our collective vested interest in this, I think it is bad because of the overall effect on the health service delivery system in the States. I do not, for one minute, believe that the State priorities will be in the areas that we are primarily concerned with. There is just enough history to know that that is not going to happen. The other part, which has been discussed somewhat by the press and other media, is the fact that actually it results in a reduction because of inflation and some complications in calculating the total amount of money which would be going to the States.

The obvious appeal in a populist sense is that the statement can be made that we then do not need any bureaucracy, other than 100 people to maintain the accounting books in Washington, and you give the programs to the people and the people will do right. That may be catchy, but it really is not either true or desirable. The other problem that we face is closely related to that and is back to our own agency and our ability to function in the area of this program, as well as others, in anything remotely like the manner that we have in the past. We have gone through reorganization after reorganization until they are even tired of calling them that, so what we are presently going through is called a "realignment." While I am out here we are being realigned back home and I

will go back to a different office than the one I left. Along with these reshufflings, of whatever name, there is an inevitable attrition of people who are related to the programs. Every time a vacancy occurs the position somehow mysteriously vanishes. So that whether we are talking about our professional consultants, the people in speech and nutrition, and nursing and so on, or those of us who have to do with the administrative end of the program, inevitably the positions vanish and functions are placed elsewhere. One of the things that will have direct bearing on you is a dictum from the front office that all matters relating to budgetary changes will be signed off by the grants management officer, which is not me. Heretofore, as you know, you agree or disagree with me but you get back a letter that says that you are approved or not approved for some activity. I have kind of continued doing that but I suspect that the other shoe will drop shortly and you may be getting back these kinds of responses from a name which is totally unfamiliar to you. And, with somebody else viewing it there will be a different set of criteria to which you will have to respond and different kinds of information and so on. As you know, the formal approval of funds comes from yet a different level, and has now for the past couple of years, from assistant bureau director's level. These things may be good or bad, but the point is that there is an increasing diffusion of responsibility and authority so that we sort of flounder. You are not getting good service and I feel, at best, embarrassed about the way we sometimes do or do not react to your needs. But along with that, and a very direct part of that, is our inability to even adequately plan. There has been discussion with some of you here about your concern as to whether there will be further meetings of this kind and so on. I do not know how to answer you. In the old days it would have been simple enough to discuss, to agree or disagree, and have some reasonable assurance that when I went back the people to whom I was responsible would be supportive, and the resources could be committed. I do not have that feeling any more. I do not mean that

we are totally without effect, but it is a gradual process which makes us less and less able to respond and I think that has some very serious implications for the Federal stewardship of this program. I do not have an answer for it but I think you should be aware that this is the kind of thing that is going on. In terms of giving you some assurance that there is money or would be money available for expansion into formal training for administrators, for both reasons, I think at the moment the answer is no. Not because of lack of commitment, but simply because of lack of anything to commit. There is not any disagreement on the part of anybody in the agency that you would have to overcome in order to train administrators. This principle has been accepted and encouraged by everyone on the staff, not just those of us on the administrative end. But I do not think the wherewithal is there and if you are going to do it, it is going to have to be a program decision on your end which calls for reallocation of funds presently committed to another purpose. You and I know what kinds of battles that precipitates in your own centers. I think that is all I can say on that subject. I will certainly be happy to respond to any questions you might have, or any comments.

Discussion

Q: Where does Jimmy Carter stand on all this?

A: I do not think he has every heard of this. Bear in mind that in our agency, the program to which you relate mostly is just one part of an overall program. It is not a discrete entity such as it is with DD or perhaps BEH or some of the other programs. We do not have any separate UAF legislation and there is not, in fact, a word in our legislation or in our regulations which even mentions UAFs. This is just a $16 or $18 million dollar part of a $290 million dollar program. That has actually been in our favor and yours in the past, because it has been the object of numerous attempts to carve it out and throw it away. Because it was just a part of a much larger program it has

survived. There has been a degree of stability there but the problems I was talking about relate to our whole program and therefore indirectly affect you. I think it is important to recognize it. As I say, neither legislatively nor by regulation is this identified as a separate program. It is a programmatic designation only.

Q: Why have there been efforts to carve it out and throw it away?

A: Because there have been very strong feelings on the part of the administration in the past that training was something the Federal government ought not to be dabbling in. There has also been an effort on the part of some people to use MR money for other purposes, and there have been efforts to transfer all of the MR functions of the maternal and child health program to other agencies, which would include the UAF and a great deal more. You may not know this but in terms of the mental retardation effort the UAF program is, at this point, just a little over half of what we directly commit for support of MR programs. So, our whole MR effort is no way directly related to the UAF program but to the services within the States and to some other kinds of training programs and so on. There have been a variety of reasons why they wanted to do this but, because it requires legislative change and because in many ways you just cannot carve it out of the rest of the program, they have never succeeded.

Q: What impact on legislative actions will this fiscal year change have?

A: The change in the fiscal year? I do not think that will have any bearing on it. We might discuss that a moment because I have had inquiries from many of you. I do not know if you are all aware of the change in the Federal fiscal year. Because Congress has chronically been unable to get the appropriation process completed by the end of June, beginning this year the Federal fiscal year moves up 3 months and will now be October through September. That leaves what bureaucrats call the "wedge period," which is the 3 months from the end of the present fiscal year until the beginning of the next fiscal

year. There is a separate appropriation for that and basically the way it will work is that we will get, within the 3-month period, enough money to fund all of those activities which we normally fund beginning July 1. So, this will in no way directly affect any of your budgets. We will not be changing budget periods, you will not be getting 3-month budgets, etc. You will never know that this happened. In the long run, it is probably an advantage because now those of you who are on a July through June basis are never sure, as we are never sure, when your funding comes due that we have an appropriation or where we stand. After this year you will be 9 months into the next fiscal year and by then we certainly ought to know whether we do or do not have an appropriation and can give you a little lead time if there are changes or this sort of thing. But there should not be any direct affect on your programs because of that change.

Q: Is the level of funding going to be the same as the current fiscal year?

A: The wedge period funding calls for continuation at the same level as this year.

Q: So, we just figure a quarter of a year for that?

A: No, you would figure 12 months. I said that we get enough during that quarter to fund everything that we normally fund during that period and that is for a 12-month period.

Q: The projects for the fiscal year do not change?

A: Project budget periods do not change. Ultimately, if we make some adjustments they may but until we are told or unless you are told, the answer is no and for most of you this probably will never happen. We do not see any reason to change.

Q: Are you speaking just for your agency or is this true for DD too?

A: I do not know how they are going to handle it. The principle is the same, of course. If the total Federal government changes, it is for everybody.

Now, how individual agencies will handle it I cannot say because there are different funding patterns and so on and I do not know how DDO will do it.

Q: Can you comment regarding the discussions that have taken place this past year, the past 6 months I guess, on the third party reimbursement and utilization of those funds?

A: First, let me say what the HEW policy is. Technically, it is permissive. By that I mean that it gives the agencies some discretion as to how income is handled. Beyond that they do openly encourage, of course, the generation of as much revenue as is possible in all of the programs. Our own policy, speaking for the MCH program, is, in fact, for most of our programs, directly in line with that. Those of you who are associated with some of our service programs are encouraged by the MCH staff to do exactly that to the extent that it is feasible and does not interfere with the provision of services, which always has to be remembered. You certainly are free and encouraged to collect fees and to apply those back to the program but we have always made a distinction between service programs and the training programs. And I think for good and proper reasons. I will speak on that in a moment, but I want to clarify one other thing. Throughout all of our programs, and this has always been true, there has been a prohibition on charging the patient or the family for diagnostic services, and that is in the regulations which govern your UAF programs as well as all other training programs. The reasons for this are multiple but perhaps the most over-riding and best understood one is the fact that from the beginning of the crippled children's program, which is where this policy first originated, there has been argument that one ought not to exclude from service anybody until there has been a diagnosis made and we have some index of how many of what kinds of conditions are prevalent in the general population. Beyond that, once you know what you are dealing with, then you may or may not charge according to ability to pay and so on. So, the patient or his family in no instance is to be charged by your programs under support you get

from us for any diagnostic service. However, and this is not clearly understood, third party payors may and should be charged. So, the prohibition extends only to the patient and his family. For therapeutic services, remedial services, of whatever kind, you may charge the patient, the family, third party payors, whomever, with the proviso that you may not exclude from service anybody who has an inability to pay, or that you will not provide a service which is different from that you would provide somebody who had ability to pay. So there is not, nor has there ever been, prohibition against charging for services. There are some conditions but they are really not that significant.

Q: How do you rationalize or explain to additional funding agencies or additional referral agencies the fact that you can be, and I use the word advisedly, discriminatory inasmuch as we may accept the money that comes from a third party and not charge the patient?

A: The only rationalization you can make is that by Federal regulations you are prohibited from doing it.

Q: Is there further rationalization for that regulation?

A: Not beyond what I have told you. There are some side issues, yes, but that is the primary reason. It is in essence an expression of national policy that we should--to be very clinical--we should index the crippling and disabling conditions which exist within this country. And if you preclude people from even being diagnosed you would never know the extent of the problem you are dealing with. In an oversimplified way, that is really what it is and it is in that sense a very real expression of the national policy relevant to health.

Q: I understand that clearly. The difficulty that I had is the acceptance of funds during the early part of the year.

A: Why?

Q: Because it seems, at least to me, that I feel that it is discriminatory.

A: Well, it is discriminatory. You cannot rationalize it off and say it is not. But, I do not think that that is necessarily inappropriate or that it is a bad policy.

Q: Why are third parties willing to pay when they can get it free?

A: Because they have, in most cases, a legal obligation to pay. It is that simple.

Q: You say that we can charge third party payors but not patients. Medicaid says that if you charge Medicaid patients, you have to charge everyone. This, apparently, is in violation of your regulations.

A: On the surface that is true, but it is not true because there are agreements between the crippled children's program and Medicaid in which this is a clearly understood and accepted part. So, Medicaid does accept the principle that has been handed out. That does not mean that Crippled Children's Agencies have not had some battles on their own homefront, but they have worked it out.

Q: It is my impression that most of the third party payors say that you may not charge them unless you charge everybody.

A: O.K., and your policy is that you charge everybody except those who, by Federal regulation, you are prohibited from charging.

Q: In New York City the Medicaid officer, who is offset by city and State regulations, says that in cases where you cannot collect money you cannot avoid those and not provide service to them. So, there are all kinds of conflicts of the law.

A: There are different laws for different purposes and they do sometimes come into conflict. This is one area but it is not unresolvable because there are many, many instances in operation, including Johns Hopkins, where by agreement Blue Cross pays, State crippled children services pays, Medicaid pays and so on. It is a problem but it is not unresolvable. Historically, we have not encouraged the training programs for two reasons. Both, I think, were practical.

First, there is that very fundamental matter that most of the training programs are primarily involved with out-patient services and with the kinds of services which in-and-of themselves do not generate enough revenue to worry about. I think many of you have found that to be true. We keep coming back to Hopkins and there is no use in beating around the bush, they do generate a lot of income. The only reason they do is because they have a very large in-patient unit and, lest you get stars in your eyes, let me assure you that the amount of income they generate from that unit does not pay for the cost of it. So we will dispense with that.

Q: By the way, we tried that route of the in-patient unit and I agree, do not do it unless you have a real large unit. We have a very small 12-bed unit. Economically, it is not feasible.

A: Well, it is not for their 40-bed unit either.

Q: I am sure it isn't.

A: I will come back and speak on that because it gets into another issue that we are concerned with, but as to the reasons why we do not; first, there is that basically we are not going to make much money off of your primarily out-patient kinds of activities and the nature of the services that you are rendering to these people. You are not a surgical ward and you do not have nice clean, discrete, entities to deal with. That was reason number one. Reason number two is that in both our service and our training programs in the past we have noticed an inevitable skewing of programs in the direction of money-generating activities where there is a fee system in operation. Despite everybody's intention and most honorable actions and so on, this tends to happen. We do not think that this ought to happen. You are a training program, you were funded to do training and that plan should be based not upon whether or not a given patient is going to generate revenue for you but whether or not it is an appropriate case to be used to meet your training mission. So, for these two very basic reasons we have not encouraged the training programs to collect

fees. By the same token, that does not mean that you cannot or should not where it is appropriate. We would have the same reservations, however, if you do get into a fee business. We will look and look very unhappily if we see that the kinds of patients you are selecting are coming to be more and more middle, and upper middle, and upper class who can pay, whether they have conditions which generate more revenue than other conditions which do not and so on. From a programmatic standpoint that has nothing to do with the money, we would say no-no to that. I think that some of these reasons, which we have expressed in the past, have created the impression that we said you cannot charge and so on. We have never said that. We have not actively encouraged the training programs but we have not said you cannot. As long as you understand what the general rubrics are then there is no problem. Now, as to the issue of what happens with that money. To oversimplify, any income which is derived from services from a training program we say unequivocally must be prorated in accordance with your various sources of support, and that percentage which relates to the portion of support you get from us comes back to us. This is where the unhappiness usually begins, because it is not understood why we are doing this. The reasons again are two. The first directly relates to what I said to you a little bit ago, that we do not think a program should benefit directly by skewing its patient load in order to generate more revenue and therefore keep more and generate more and so on. The second reason is that we do use the money which comes back to us for the general program purposes. In other words, it all goes for the same kinds of functions as you perform but not necessarily directly to your program. Now, let's get very specific on that issue and back to our friends at Hopkins. Too bad no one is here from Hopkins. They could talk about their own views of this. But, I think it makes the issue much better understood. In the support of the UAF programs from MCH--let's use very round numbers--let's say that our support to your programs amounts to $16,000,000, which is very close to what it is. That $16 million dollars is

composed of two things: an appropriation and roughly $1 million dollars that we get back from your programs in terms of what you have been allocated but have not spent, the carryover amounts, and from the income generated by a few of you, but primarily by Hopkins. So, we are talking about $16 million dollars worth of programs operating on a $15 million dollar appropriation. Now, it is that simple. We have so much money, and only so much, it all goes into the programs and it comes from those two sources. The simple fact is that if we permit Hopkins or anybody else to retain the income they might generate, we can only do one of two things. Either let them retain that income along with as much money as we have been giving them and thereby cut out one of your programs entirely--because that is what it would amount to--or we can reduce the allocation to Hopkins from our appropriation by the amount of their anticipated revenue and life goes on as it always has. In the one instance, at least one of your programs would benefit, or two perhaps, and the rest of you would suffer, or else one of you would be simply wiped out. We do not choose to utilize that option. If one of you would like to volunteer then I am certain some of the other programs would be very happy, but I do not think that is going to happen.

Q: Third party payments have to be returned also?

A: The source is irrelevant.

Q: I have a series of questions. In terms of the training and services support, what we have is very different than a lot of the other units.

A: How is it different? Are you talking about the support you get from us being different, or your overall support?

Q: The overall support. Might it be advantageous for us to think in terms of separating our service staff and training staff, and letting the service units retain the income they get?

A: That has been suggested by a number of places. You are perhaps in a better position to do it than most would be, but there is a problem with

that, unless you have really a discrete, identifiably separate service unit which does not relate to the training program then you have problems. We are not willing to accept that patients coming into a facility who are being serviced by primarily those faculty and staff that we support, or by a mix of them, can somehow be segregated and this group labeled as service and that group as training and you keep the money on the service and you do not on the training. I do not think that is feasible, and programmatically you are going to have to be terribly persuasive to convince us that this is the way it should operate. For situations where you have a discrete unit or a separate service base off somewhere else that is clearly identifiable, and that may only incidentally be related to the training program, we have something to talk about or maybe do not even need to talk.

FUTURE PLANNING

Jerry O. Elder
Administrator
Child Development and Rehabilitation Center
University of Oregon Health Sciences Center
Portland, Oregon

Where do we go from here? I would like to conduct this session with your active participation. I will throw out some suggestions for future steps and ask you to react to them, either favorably or against them and to provide some additional suggestions back to me. Please feel free to make comments as I review the future.

Model #1

In Model #1, the core curriculum, we discovered after Andre Delbecq's presentation, that we have a long way to go before implementing some of the core curriculum concepts. It can be done either by individual UAF administrators in their own University Affiliated Facilities (UAF) or by UAF administrators as a group. Dr. Delbecq gave us the mandate of going through problem identification knowledge exploration, preliminary design, proposed review and implementation, etc. as a group. Now, that does not say that you cannot do it individually within your own UAF as some of you already have. But, for the administrators as a group to provide some push to the directors and other members of the UAF staffs I think we need to go through the whole process of problem identification, preliminary design and implementation. How we are going to do that depends upon some additional funding.

COMMENT: Are you suggesting the technical assistance structure that this group can provide:

ELDER: If we were to propose a grant request to set up some technical assistance either among ourselves or obtain some outside help we would need to set up a plan, per Dr. Delbecq's scheme. This scheme would include a plan

for administrative subjects in a core curriculum, the establishment of a team, and a package program which UAFs could buy or participate in.

Most UAFs have core curriculum, but, there are very few UAFs that include administration as an integral part of that core curriculum. Getting that into the core curriculum means a battle with your UAF staff, convincing them that this is important enough to fund at the expense of something else. Our core curriculum is also so crowded that we cannot get much more included.

By going through the Delbecq scheme of defining the problem, setting out a plan for action which we have already done in Model #3 through the publication of the position paper and the previous workshop and grants, we can hope to include administration in the core curriculum. Once that plan is established we can then set up a package program, identify the people who can teach these subjects or identify programs who have a package that could be exported to another UAF. In other words, if Ed Linzer has a good program he could come to my place and help me set it up.

COMMENT: Another approach would be to make this a regional program so we do not have to transport people all the way across the country. Maybe we could divide up into regions and identify support people within each region who could help those "young" UAFs that are just now beginning to get started or have not yet developed a good core curriculum program.

COMMENT: I would like to comment on what Jerry is sort of proposing in a couple of respects. First, for those of you funded by us, if indeed one of you was asked to go from one of your programs to help somebody else, this would not require approval from us. We would agree that this is an appropriate function in your line of duty. Secondly, if you have this function as part of a separate grant I do not think it would not be an appropriate kind of activity to fund a grant. There is a third possibility which there is some time lag involved, but maybe it should be considered. We have an administrative mechanism within the bureau which permits us to write personal services contracts. There

may be some potential for us contracting with one of you to provide technical assistance in this area. It is a personal services contract, pure and simple. We would hire you to perform a task. The personal contract idea may take some time, but it is possible.

It is your job to teach administration and to get it into the core curriculum. To help you in this endeavor you have interdisciplinary councils in the AUAF, you have seats on the administration of the UAF association, and you have positions in your own UAFs. You have got to do some selling. The other people have done this. You happen to be the last discipline who has gotten around to this kind of thing. Early in the game, some of the disciplines had exactly these same kinds of sessions to define what their role was and where ought they go and how ought they relate to other people, and so on. What you are suffering primarily is coming along a little later than most but you are not that different. You have to go back and sell. There is not any other way of doing it.

COMMENT: I think that most of it can be done on the individual UAF level. I think that is where the biggest impact can be made. Each individual UAF administrator working with his own staff. Because, you know, we cannot foresee any outside help.

COMMENT: It seems to me that the importance in getting this done is well established. There is no problem there. I do not foresee any problems at all in getting this into the core curriculum. I think that the thing that would be helpful would be if we could arrive at some sort of standardized approach to what we give to the core curriculum.

ELDER: That was what we originally started with in the document I showed you Monday that Walter Throop developed. That needs some reworking. I do not use that outline per se but it provides some general ideas. Could we get a grant to redevelop or refine it?

COMMENT: You could get a grant for a meeting that would lead to a

conference. As I was commenting to a couple of people at the coffeebreak, I just do not know this year whether we are going to have any money for conference grants. Last year, half of the world was committed to conferences and meetings. This year I would not bet on any. There may be, but I doubt it. In a practical matter I do not know if any are going to happen.

Model #2

ELDER: The administrative residency really is a part of Model #3 but it can also be separated out as Ed Linzer has illustrated. You can pick up an intern or a resident from an established program outside of the MR, DD, or mental health field, or any type of a student who is looking for this type of an experience. And, again, the implementation of that model depends upon you and the negotiations you make with that student or with the program that student is coming from. When you get the proceedings of this conference you can take a look at what we came up with from the Nominal Group Technique and apply those steps for implementation and obtain some suggestions from that. Again, I think it is up to the individual UAFs' administrators to negotiate those arrangements.

Model #3

ELDER: Just about all that can be done has been with the publication of the position paper. It is up to us now to implement the recommendations made in it by working with graduate programs looking for funding resources. One of the major recommendations was that we work with the AUPHA and existing graduate programs in health administration. I think, also, after Tom Natiello spoke yesterday, we might investigate contact with the Academy of Management and see what type of programs they represent. Tom's program seems to be a good example. I felt that his program is more open to suggestions and changes. They do not seem to be as rigid as the graduate programs AUPHA represents. Did anyone else get that impression?

COMMENT: I would like to comment on that Jerry. John Kralewski has a sort of personal antidote. Several years ago, shortly after he first arrived in Colorado, I had the occasion to discuss with him the possibility of this kind of a program. It became evident he was not interested in training anybody who would get grubby hands from working on administration and so on. When we met him last year and again at this meeting today, his thinking is entirely different and favorable to our concept. I think the main point is that the graduate programs themselves are susceptable to change. John had exposure to the UAF at Colorado, began to look at the field in terms of what was needed and what contribution they could make. I think John has made a very legitimate change on his part. I think others will also change.

ELDER: What John alluded to yesterday, but did not come right out and say is the hospital administration field is saturated. They are putting out more graduates than the field can absorb and so they are looking for other areas to place graduates and that is why their programs are changing. The AUPHA used to stand for Association of University Programs in Hospital Administration; it is now Health Administration. A lot of the programs have changed their name from hospital to health administration, but in reality, they are still hospital administration training programs. Their graduates are going out, if they want to go into a hospital, into departmental level positions--middle management. Therefore, if a graduate wants to get into a second level management position, a little higher level than the department head, they are looking to other fields. That is the reason that mental health administration programs are developing. I think the time is right also to develop a MR/DD track.

COMMENT: How can be announce other types of programs as a result of this conference?

ELDER: We are making that word known through our coordination with the task force on mental health and mental retardation administration. Vic Keeran

is a member of the task force. I am not a member per se but I am on two subcommittees for the task force and so through Vic and I we are providing this input.

COMMENT: Let me make one more comment about Kralewski and his attitude. When I first got my faculty appointment, one of the first things that John asked me was what kind of stipend do you have for trainees. At that time the stipends were all out to other disciplines and they still are. I told him there was no stipend money and this was what happened. He very quickly got busy in really pursuing the administration aspects in the UAF. With that, as you have said, John has turned 180 degrees and I think now has an interest exclusive of stipends for trainees. Jerry also said, they are looking for additional fields of specialization in their health administration training programs.

COMMENT: Now, there is another factor entering into this. In medical schools with all types of patients there is an increasing emphasis upon the interdisciplinary approach and, as far as I am concerned, the UAFs are a delightful model for interdisciplinary programs. But, I think we have a little leverage there. I look at our UAF as a member of an interdisciplinary model for what is bound to happen in the health field.

ELDER: The people who are going to be opposing us on this model are those who believe that administration should be taught in the human services model. We acknowledge that fact in the position paper. However, we are looking at it from the more restricted view of the health field as one common element so we feel that the health administration field is the appropriate area.

COMMENT: I would like to comment on Vern's reference yesterday to the initial efforts of getting a program started at Ohio State. The reason at first, preventive medicine was unacceptable to us and the revision was unacceptable to them, was that, in fact, the curriculum was so full of things they wanted in it that the person actually would not have had enough time in the

clinical program to justify our support. You cannot get into that kind of situation. We are not at all interested in providing stipend support for somebody who will be no different in that graduate training program than they would have been otherwise. So, there was simply a disagreement there--we would not agree to support them with a minimal commitment to the program. So, that is why the first effort went down the drain. You have to have enough time for the individual in your program to justify his being there as with all other disciplines or MCH will not be interested.

ELDER: In summary, I think there are very few additional things that we, as a group on the national level, can do without additional funding, but there is a lot that you as individual administrators can do in your individual UAFs. Hopefully, we have given you some direction and guidelines during these 2½ days to pursue this further, and we wish you luck.

One further comment, any of you who have put together a conference or workshop like this know the amount of time it takes to put it together and the commitment it takes and I just wanted to thank Wil Clouse for his excellent organization of this conference.

COMMENT: I would like to go a little beyond that if I may. I certainly second what Jerry has said in regard to Wil but I think you also owe Jerry a great deal because although we provided some incentive and a little financial resource, the continuity of this movement, the effort of the past that led up to this meeting, and so on, have largely been because of Jerry's shepherding of it along with help from many of you. But, we has been the central figure and it simply would not have happened otherwise. So, to both Wil and Jerry and the rest of you I would like to express our official thanks and to say that I think that we have gotten a good investment on the public's money.

Closing Comment

From my standpoint, I think the conference has been a success and I think the successfulness of it has been primarily related to you as participants and not to those of us who planned the conference. Each of you have interacted very well and have expressed many interesting ideas. I am delighted that you chose to be with us for the past 2½ days and I hope to see you again sometime in the future.

APPENDICES

APPENDIX A

National Conference

For

Administrators of University Affiliated Facilities

ADMINISTRATORS AS EDUCATORS

February 23 - 25, 1976

Adams Hotel
Phoenix, Arizona

Sponsored By
Maternal and Child Health Services

CONFERENCE OBJECTIVES

- To emphasize the importance of interdisciplinary administration training.
- To review the history and background of UAF administration training programs.
- To investigate the three administration training models in UAFs.
- To examine the role of the UAF administrator in teaching administration.
- To determine the requirements and role of a preceptor.
- To develop a plan for administration internship.
- To develop a plan for relating to academic health service administration training programs.
- To learn and to apply the Nominal Group Technique in decision making.
- To explore funding possibilities for administration training programs.

NATIONAL CONFERENCE

For Administrators of University Affiliated Facilities

THEME: Administrators As Educators

SUNDAY EVENING, FEBRUARY 22

5:00 - 6:30 p.m. - *Social Hour*

MONDAY, FEBRUARY 23

8:15 - 8:30 a.m. (Havasupai Room)
Registration and Coffee

OPENING SESSION: (Havasupai Room)

8:30 - 9:30 a.m.

Opening Remarks — *R. Wilburn Clouse, Assistant Director for Administration, The John F. Kennedy Center, George Peabody College*

The Importance of Interdisciplinary Administration Training in UAFs — *William Gibson, M.D., Director, The Nisonger Center, Ohio State University*

Brief History and Background of UAF Administration Training Programs — *Jerry Elder, Administrator, UAF, University of Oregon Medical School*

9:30 - 9:45 a.m. - *BREAK*

SECOND SESSION: (Havasupai Room)

9:45 - 12:00 p.m.

Model 1 — *Administration Training in the UAF Core Curriculum*

Moderator: — *Melvin Peters, Administrator, Child Development Center, University of Tennessee*

The Importance of Administration Training in the Core Curriculum — *Charles Keeran, Associate Director, Neuropsychiatric Institute, Mental Retardation Program, UCLA*

(SECOND SESSION CONTD.)

Core Curriculum Administration Program: A UAF Model	*Adrian Williamson* *Acting Director, UAF* *University of Colorado* *Medical Center*
The Role of the Administrator in the Core Curriculum Administration Program	*Henry Schulte* *Administrator* *Child Development and* *Mental Retardation Center* *University of Washington*

Open Group Discussion

12:00 - 1:00 p.m. - *LUNCH* (Pima Room)

THIRD SESSION: (Havasupai Room)

1:00 - 2:15 p.m.

Model 2 *Preceptor-Intern Relationships*

Moderator: *J. Robert Gray, Administrator*
Division for Disorders of
Development and Learning
University of North Carolina

Preceptor-Intern Relationships in Administration Training	*Jack Malban, Ph.D.* *Project Director* *Mental Health Administration* *Training Program* *University of Minnesota*
The Role of the Administrator As A Preceptor: A Practical Experience	*Edward Linzer* *Administrator* *Rose Kennedy Center* *Albert Einstein College* *of Medicine*

2:15 - 2:30 p.m. - *BREAK*

FOURTH SESSION: (Havasupai Room)

2:30 - 4:45 p.m.

Model 3 *Administration Degree Programs:*
UAF and University Relationships

Moderator: *Jerry Elder*

(FOURTH SESSION CONTD.)

The Need and Justification for Interdisciplinary Health Service Administration Degree Programs	*John Kralewski, Ph.D.* *Director, Program in Health Administration* *Department of Preventive Medicine & Comprehensive Health Care* *School of Medicine* *University of Colorado Medical Center*
Organizational Criteria and Content Overview of Interdisciplinary Health Service Administration Training	*Walter Burnette, Ph.D.* *Director, Graduate Program in Health Services and Hospital Administration* *Tulane University Medical Center*
An MCH Approved Administration Program	*Vern Reynolds* *Administrator, The Nisonger Center* *Ohio State University*
A Proposed Administration Degree Program	*Thomas Natiello, Ph.D.* *Director, Institute for Health Administration and Research* *University of Miami*
Small Group Meeting *Model 2* (Havasupai Room)	*Robert Gray -Discussion Leader*
Model 3 (Gila Room)	*Jerry Elder -Discussion Leader*

TUESDAY, FEBRUARY 24

FIFTH SESSION: (Havasupai Room)

9:00 - 9:30 a.m.

Continuing Education for Interdisciplinary Administration: A Progress Report — *Charles Keeran*

9:30 - 10:30 a.m.

Theoretical Concepts of the Nominal Group Technique — *André Delbecq, Ph.D.*
Professor, Department of Management, Health Services and Public Management
University of Wisconsin

10:30 - 10:45 a.m. - *BREAK*

(FIFTH SESSION CONTD.)

10:45 - 12:30 p.m.

Nominal Group Technique Workshop — *André Delbecq and Ms. Sandra Skubick, Program Assistant, Department of Management, Health Services, University of Wisconsin*

Group 1 - Model 1 (Havasupai Room)

Group 2 - Model 2

Group 3 - Model 3 (Gila Room)

12:30 - 1:30 - *LUNCH*

SIXTH SESSION: (Havasupai Room)

1:30 - 2:15 p.m.

Group 1 Presentation and Open Discussion

2:15 - 2:45 p.m.

Continuation of the Nominal Group Technique — *André Delbecq*

2:45 - 3:00 p.m. - *BREAK*

3:00 - 3:45 p.m.

Group 2 Presentation and Open Discussion

3:45 - 4:30 p.m.

Group 3 Presentation and Open Discussion

4:30 - 4:45 p.m.

Summary — *André Delbecq and Ms. Sandra Skubick*

WEDNESDAY, FEBRUARY 25

SEVENTH SESSION: (Havasupai Room)

9:00 - 10:30 a.m.

Administration Training: Funding Criteria and Possibilities

Maternal and Child Health Guidelines — *James Papai, Chief, University Program Section, Health Services Training Branch, MCHS*

Developmental Disabilities Guidelines — *George Shepard, Chief of UAF Division, Developmental Disabilities, Washington, D.C.*

Office of Child Development Guidelines — *TBA, Representative, Office of Child Development, Washington, D.C.*

10:30 - 10:45 a.m. - *BREAK*

CLOSING SESSION: (Havasupai Room)

10:45 - 12:00 p.m.

Conference Summary	*R. Wilburn Clouse*
Future Planning	*Jerry Elder*

APPENDIX B

CONFERENCE PARTICIPANTS

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* Speaker

APPENDIX C

CONFERENCE CONSULTANTS
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